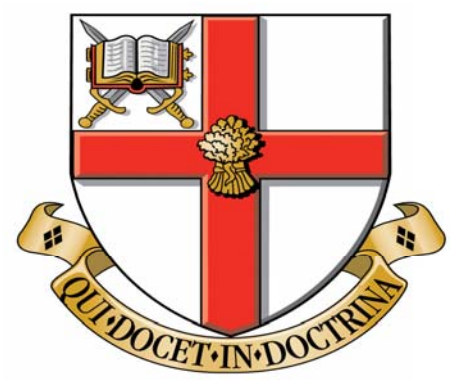

PERSON-CENTRED COUNSELLORS' ASSESSMENT FOR BRIEF THERAPY. A SMALL SCALE QUALITATIVE STUDY OF THE EXPERIENCES OF PERSON-CENTRED COUNSELLORS WORKING IN A BRIEF THERAPY SETTING.

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ABSTRACT

Assessment is considered a key ingredient of brief therapy and yet it is antithetical for many person-centred counsellors. Consequently, there has been little research into how person-centred counsellors assess for brief therapy, if indeed they do. Moreover, there is limited guidance from the literature to assist the person-centred counsellor in this respect. Being informed by Wilkins and Gill's (2003) research, this small scale, qualitative study used unstructured interviews to explore the experiences of five person-centred counsellors who worked in brief therapy settings. Verbatim transcripts from the interviews were analysed using the constant comparative method of data analysis. The results indicated that the process of assessment was not a separate event that could be isolated and analysed critically, but was contextual and continuous throughout therapy. The outcomes showed support for Wilkins and Gill's (2003) research and point to a theory of assessment based on a judgment about aspects of the relationship. Implications for training, research and practice are discussed.

The work is original and has not been submitted previously in support of any qualification or course.

Signed .....

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LIST OF ABBREVIATIONS

BACP	British Association for Counselling and Psychotherapy
BAPCA	British Association for the Person-Centred Approach
CBT	Cognitive Behavioural Therapy
DH	Department of Health
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PCA	Person-Centred Approach
UK	United Kingdom
USA	United States of America
WAPCEPC	World Association for Person-Centred and Experiential Psychotherapy and Counselling

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CONTENTS

Reaching no absolute, in which to rest,

One is always nearer by not keeping still.

(Thom Gunn. ***On the Move*** *'Man, you gotta Go.'*)

CHAPTER ONE

INTRODUCTION

Over the last forty years there has been a steady trend towards the practice of briefer forms of therapy, or therapy which is offered within a specified time limit (Budman & Gurman, 1988). A key ingredient for brief therapy is the initial or assessment session, which is felt to be paramount, whatever the therapeutic approach taken (Wells & Gianetti, 1990).

The notion of assessment, however, is considered by many to be antithetical to person-centred practice (Mearns, 1997). Nevertheless, within the person-centred tradition, there are many 'tribes' (Sanders, 2004) and the position with respect to assessment is complex (Wilkins & Gill, 2003). Even within the wider therapeutic community, there is considerable disagreement as to how to assess clients (Aubrey, Bond & Campbell, 1997; Milner & O'Byrne, 2003).

As a person-centred counsellor working in primary healthcare, I offer brief therapy to four busy General Practitioner (GP) practices. I am required to offer an initial assessment session to assess suitability for brief therapy and am aware of my early attempts to integrate the requirements of the agency within my counselling philosophy. Working in primary care, I am also part of a multi-disciplinary team where the prevailing culture follows a reductionist, scientific paradigm of assessment, diagnosis and treatment. Such a model stands in opposition to a person-centred ideology, which is essentially humanistic, holistic and phenomenological.

Feltham (1997) states that person-centred counselling does not fit easily with brief therapy and for all models of counselling, a degree of eclecticism is necessary. Pembroke (1999) acknowledges the diverse training backgrounds of primary care counsellors, stating that no one approach is adequate for all problems and advocates additional specialist training in primary health care counselling. As a person-centred counsellor committed to the approach, I do not have additional specialist training, nor do I consider myself eclectic or integrative. When I first took up the position, I had

misgivings about what to do and whether I needed to adapt, modify or integrate my approach. Additionally, I found there was a notable lack of guidelines and research from a person-centred perspective. Faced with the lack of supporting literature, I did not feel in a strong position to defend my chosen approach.

With no accepted model of person-centred brief therapy or assessment as a guide, my research question emerged as I wondered how other counsellors managed to assess for therapy and whether this involved an adaptation or compromise to their practice. Was it indeed true that one's personal model of counselling may need to be abandoned in order to work effectively within brief therapy? By exploring the personal meaning of assessment for person-centred counsellors, I hoped to understand the processes involved for the counsellor in deciding whether to offer brief therapy and hoped this may offer some guidance to other person-centred counsellors working for the first time in brief therapy.

The move towards evidence-based practice and the publication in 2004 of the National Institute for Clinical Excellence (NICE) guidelines for anxiety and depression recommend cognitive behavioural therapy (CBT) as the treatment of choice. CBT speaks the language of evidence-based practice; it routinely uses psychometric measures and presents a strong research base to back up its claims. The fear among many is that other, less researched therapies will become marginalised (Jones, 2007; Haydon, 2008). The person-centred approach has a comparatively weak research base with a lack of contemporary research that meets the 'gold standard' of randomised control trials favoured by NICE. Moreover, it is currently undergoing a crisis with regards to its membership (Sanders, 2008). Regulation poses a real threat to the future of the approach, as currently it is not recognised by the government (Wilders, 2008). In order for the person-centred counsellor to assert herself with credibility in these changing times, I believe it is important to have dialogue with colleagues working from different modalities and to have mutual understanding of our approaches. As Wilkins (2005, p. 133) states: "it is not that we have a disregard for assessment but that we have a different set of theories and procedures which take the place of the more conventional approaches." I hoped my research would go some way towards reaching some mutual understanding of assessment from a person-centred perspective.

Two earlier studies into client assessment from a person-centred perspective have informed and prompted this research. Wilkins and Gill's (2003) study of assessment focused on person-centred counsellors who worked in a healthcare setting and Milner and O'Byrne's (2003) study explored assessment across a range of counselling approaches. Neither study was limited to those counsellors working to a brief therapy contract and I am interested in whether this would have any impact on how the first session was used. Therefore, it is the experiences of the initial session by person-centred counsellors, working within a brief therapy setting that forms the focus of this study.

Aims and objectives

The central aim of this research was to explore person-centred counsellors' assessment for brief therapy. Using a small scale qualitative study I wanted to explore the experiences of person-centred counsellors working in brief therapy and understand more about the process of assessment.

The aim was not to find universal truths but I hoped to learn something that could be added to our understanding of the process and which could have implications for person-centred counsellors and for the wider therapeutic community.

I use the terms counsellor, therapist and psychotherapist interchangeably as this reflects their use in the literature. Rather than use he/she throughout and in an attempt at gender neutrality I have chosen to use the pronouns 'she' to refer to the therapist and 'he' to refer to client.

CHAPTER TWO

LITERATURE REVIEW

SEARCH STRATEGIES

I performed a small scale, preliminary search for the purposes of completing my research proposal, to stimulate further questions and ideas and to establish the relevance of my research topic within a wider audience. However, in the spirit of qualitative research, the major part of this work was postponed until the data was collected and analysed (Silverman, 2005).

Initially I searched for books and journals covering aspects of assessment in psychotherapy and/or brief or time-limited therapy. This revealed a number of texts but very little written from a person-centred perspective. Using references from selected texts provided links to other sources resulting in additional relevant references. To explore the person-centred literature in greater depth I used dedicated online person-centred websites and searched for dissertation abstracts, research articles, journals and bibliographies. These sites and bibliographies are listed in Appendix 1A.

Extending the search further, I used electronic bibliographic databases to search for books and original articles written in English and published in the last ten years. These criteria were adopted to ensure sufficient relevance and scope but also to restrict the search to manageable proportions in view of the time available.

I selected the PubMed (Medline) and PsycInfo databases separately to build a systematic, flexible and focussed search using the database's own indexing thesaurus for relevant articles. Copies of the full search history taken from the websites together with the key words used and resulting hits are listed in Appendix 1B and 1C respectively.

The search terms, 'assessment', 'brief-therapy' and 'person-centred' resulted in many matches but little of relevance because of the multiple meanings of these terms in different therapeutic settings. I scanned the results of all searches where the hits were less than seven hundred but found little of relevance.

I conducted a further, broader search across several databases in order to capture any articles that may have been missed using the other methods. This final search did not yield anything new and is itemised in Appendix 1D.

In addition, I performed a complete search of all articles published in the last four years in the online journal, *Psychology and Psychotherapy: Theory, Research and Practice.*

LITERATURE SEARCH

Introduction

The initial part of this review presents a short overview of brief approaches to therapy indicating relevant aspects of brief therapy from different therapeutic perspectives. A comprehensive account is beyond the scope of this review but it is intended to provide the particular context for the research.

I then present an introduction to Rogers' (1951) theory of person-centred therapy followed by a discussion of the person-centred view of brief therapy and how issues of power and locus of control have divided the person-centred community's support for such a model. I believe these current debates are relevant to a wider understanding of the tensions and challenges that may be faced by the person-centred therapist during the assessment process prior to brief therapy.

The main section of the review then examines the general literature on assessment in an attempt to present a conceptual understanding of its purpose and process. This is followed by the person-centred view of assessment in which I highlight some of the challenges faced by the therapist in remaining philosophically congruent with an

approach that may be incongruent with the social and political demands of the service in which she works.

Brief therapy

Although brief therapy is not new, it was not until the years following Freud's death in 1939 that briefer forms of therapy really began to gain prominence. The 1960s saw increasing public awareness and availability of psychotherapy and changing attitudes towards mental health provision. The emergence of cognitive-behavioural therapy, psychodynamic brief therapies and integrative models meant that there was an alternative to long, expensive therapy (Budman & Gurman, 1988).

Today, concerns with cost have continued to drive the need for briefer therapies. Within the United Kingdom (UK), the National Health Service (NHS) is currently undergoing a radical change with regard to mental health services. The government's programme, *'Improving Access to Psychological Therapies'* (IAPT), announced in February 2008 and based on Lord Layard's *Depression Report* (2006) points to the socio-economic benefits IAPT will bring to the nation. A major thrust of this programme is the recruitment of over three thousand mental health professionals who will be trained to deliver brief CBT. That psychological therapies are now being received with so much favour is good news, although clearly there are implications for therapists not allied to the brief, CBT model.

Brief counselling can extend from one to twenty sessions, depending on the theoretical approach adopted, although often between six and ten sessions are offered (Parrott, 1999). Feltham (1997, p. 28-44) and Tudor (2008, p. 2) provide a useful overview of the main approaches to brief therapy. Some are designed to be relatively brief but without a time limit, some lend themselves to short-term work and others are designed to be for a fixed, brief time limit. The terms short-term and brief therapy may be used synonymously and generally refer to a shorter form of the particular approach used.

The term time-limited is distinct from brief therapy in that the limit is rigidly set from the beginning, rather than being applied more flexibly. For the purposes of this

review, I have extended this discussion to include literature on time-limited therapy, as both are considered short-term.

In accounts of brief therapy, temporal issues become central and the use of time a tool in itself (Mann, 1981). Parrot (1999) stresses that the efficient use of time becomes a priority in brief therapy. Hoyt (1990, p. 115) too, stresses the importance of seizing the moment, the need to "get on with it" and "don't waste time" because change can occur in the moment. He suggests it is a myth to assume that "more is better" but that the brief therapist needs to be "active, intensely alert, selectively focused, intuitive and risk taking" (p.117).

Strasser and Strasser (1997) explain how the limits to time create pressures and tensions for both therapist and client and observe how therapists increase the frequency of challenging interventions in brief therapy. The constant reminder of the ending may also expedite self-disclosure for the client who may work much harder than if there was no time limit.

Feltham (1997) stresses the importance of the counsellor having a wide array of interventions to offer the client if she is to be effective but states that often "the most common practice for those practitioners unfamiliar with time-limited work is to attempt simply to do less of the same" (p. 58). He states it is not sufficient to just "give it a go" (p. 58) in the spirit of something is better than nothing, but the counsellor needs to have a positive attitude and an openness to the possibilities of short-term work.

That something different is required of the brief therapist, strikes at the heart of the person-centred approach and the principle of non-directivity, which is discussed below. To become more directive is counter-intuitive for the person-centred therapist whose primary task is to build a relationship, this being the sole means of therapeutic change (Ruddell, 1997). Person-centred therapy is not designed to be brief any more than it is designed to be long term, and many practitioners from other modalities would not consider it to be effective for brief work (Tudor, 2008). Yet many person-centred counsellors do work in settings where brief therapy is offered and so it is of relevance to consider the challenges, if any, this brings.

The literature also indicated that assessment was considered key to the success of brief therapy and that it required a particular set of skills and experience with definite tasks and goals to be achieved (see Dryden & Feltham, 1992; Koss & Shiang, 1994; Hudson-Allez, 1997; Parrott, 1999). Again, something different is required of the therapist and questions the self-authority of the client. This presents a dilemma for the person-centred counsellor for reasons that I will now discuss.

The person-centred approach to therapy

Here I present a summary of Carl Rogers' theory of person-centred therapy by way of situating the person-centred approach within the broader psychotherapeutic frame and to highlight the central tenets of person-centred theory, which are of relevance to a discussion of assessment. For a more comprehensive account of Rogers' work see Rogers (1951) or Mearns and Thorne (1999).

Person-centred therapy is grounded in a phenomenological approach to the person. Subjective experience is central as the source of self-understanding for our thoughts, feelings and behaviours and this subjective world, by definition, cannot be fully understood by anyone else (Merry, 1999). Rogers presented his theory of personality development and behaviour in his nineteen propositions (Rogers, 1951, pp. 481-533). He used the phrase 'actualising tendency' to refer to the motivational force, present in all living organisms, responsible for the process of growth and development towards fulfilment of potential and he described how constraints on the actualising tendency could arise from adverse conditions in the person's environment. Central to Rogers' approach to therapy was the hypothesis that the individual has within himself vast resources for self-understanding and change. These resources can be released if a facilitative psychological climate of growth is provided by the presence of six conditions (Rogers, 1957). The third, fourth and fifth conditions, empathy, congruence and unconditional positive regard, usually referred to as the core conditions, describe the skills, attitudes and beliefs that the therapist brings to the relationship. Therapeutic change will occur as the client comes to recognise his feelings through the medium of the relationship (Ruddell, 1997; Worrall, 1997).

The principle of non-directivity is central to an understanding of what it means to be person-centred and continues to arouse considerable dissent as it highlights the difference not only between the person-centred and other approaches to therapy, but also between the different "tribes" (Sanders, 2004) within the person-centred community (Merry, 2004). There are those who view non-directivity to be a myth (Bowen, 1996 cited in Wilkins, 2003) or even an impossible concept (Lietaer, 1998) and Grant (2002) distinguishes between 'instrumental' and 'principled' non-directiveness. Ellingham (2005) highlights the dissent and confusion within the person-centred community over the interpretation of non-directivity. He mentions how even leading advocates of the approach in the UK, such as Dave Mearns and Brian Thorne, are berated by some for departing from the non-directively pure position. Carl Rogers, too, is similarly criticised.

Much of the discussion seems to focus on the personal conceptualisation of non-directivity and causes much tension within the community (see for example Wakefield & Wakefield, 2005; Cooper, 2007; Wilders, 2007). Warner (1998, cited in Wilkins, 2003, p. 9) distinguishes different levels of intervention as indicative of different but acceptable person-centred positions. What is important here is that the person-centred family is divided along a continuum of directivity characterised by those adopting the classical Rogerian position at one end and those who adopt a process-experiential approach at the other. This debate is, therefore, relevant to consider in the discussion of brief therapy and assessment to follow.

The person-centred approach and brief therapy

Although there were several reviews of brief therapy from a psychoanalytical or cognitive behavioural perspective, (see for example, Dryden & Feltham, 1992; Feltham, 1997; Hersen & Biaggio, 2000) there was a notable absence of references to person-centred brief therapy indicating its position within mainstream approaches to brief therapy. There have been two books published which attempt to bridge the gap. Bryant-Jefferies (2003) through the medium of a case study presents a dialogue of time-limited, person-centred counselling in a primary care setting. During the research for this review, Tudor's (2008) edited book titled, '*Brief Person-Centred Therapies*' was published and uses contributions from a number of person-centred

therapists from within different 'tribes' of the person-centred 'nation' to address the question of whether person-centred therapy can be compatible and effective with brief therapy. This is perhaps an indication that brief therapies continue to be at the forefront of psychotherapeutic developments and that it is, therefore, timely for the person-centred community to respond to this trend in a thoughtful and informed way.

Rogers viewed time limits as an existential reality and advocated adherence to boundaries of time in therapy, because this established an arbitrary human limit to which the client must adjust. It was the therapist's task to help the client explore his feelings with regard to time because this would reflect his feelings and perceptions towards larger issues (Tudor, 2008). However, although Rogers did not recommend restricting the duration of therapy, he was clear that where there was an externally imposed time limit, this did not require the therapist to hasten the process in any way by becoming more directive (Rogers, 1942).

Those from outside the person-centred community, who are critical of the person-centred counsellor's ability to work effectively within a brief setting, point to the insufficiency of Rogers' (1957) six conditions for creating therapeutic change (see Hudson-Allez, 1997; Casemore, 2002). However, such criticisms reflect the views of those for whom technique and method are pivotal for effecting change and represent an entirely different philosophy. Within a person-centred context, change occurs through the relationship between therapist and client.

A reading of Parrott (1999), however, suggests there may be less dissonance than expected between the person-centred approach and brief work. Parrott (1999), a counselling psychologist, discusses the centrality of the patient's power to create change for herself and continues by stating this requires a fundamental philosophical shift about change and pathology. Such a philosophy is entirely congruent with the person-centred approach to the process of change, the inner directional flow towards actualisation and growth (Rogers, 1951).

Recent research provides further support for the sufficiency argument. Bozarth's (2002) review of fifty years of research concludes that the major determinant for therapeutic change, over and above technique, is the counsellor relationship coupled

with client resources (Bozarth, 2002). Stiles et al.'s (2006 & 2008) research also supports this view. They researched the effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies and confirmed the 'equivalence paradox', i.e. that many psychotherapies appear to have equivalent outcomes despite non-equivalent theories or techniques. Effective therapeutic change was related to generic factors, such as the relationship and client variables rather than the theoretical position of the therapist. Research by Godfrey, Chalder, Ridsdale, Seed and Ogden (2007) lends further support to this view. Their research into brief therapy with clients suffering from chronic fatigue found that it was the ability of the client to explore and process emotional material rather than specific technique that accounted for the differences in outcome.

In spite of this research, there is considerable dissent within the person centred community from those who argue that time limits disempower not only the client but also the counsellor. Mearns and Thorne (1999, p. 124) describe it as "a crude and inefficient way of structuring a counselling provision." Mearns (2002) and Goss (2002) advocate brief therapy rather than time-limited because this allows for flexibility in service provision so that the number of sessions can be extended if appropriate, according to individual need.

Wakefield (2005) also supports the call for flexibility with regard to the number of sessions. Her research showed that when flexibility was introduced an average of six sessions was maintained. Other research by Marzano (2006) found that longer therapy (nine to sixteen sessions) was more likely to produce a reduction in depression scores than therapy of less than nine sessions.

Some accounts of person-centred brief or time-limited therapy suggest the core conditions have to be offered immediately and intensely (Thorne, 1994; Gibbard, 2006). Thorne (1999), however, later asserted that brief work is "an abject capitulation to a mad world" (p. 11).

Toal (2001) does not feel that brief work requires the counsellor to work more intensely because there is then a danger this may become a technique to be communicated rather than a spontaneous attitude to be expressed and as such, could

hinder the therapeutic relationship. Using any techniques questions the sufficiency of the core conditions and generates further dissent within person-centred ranks with strongly held views at both ends of the divide (see Brodley & Brody, 1996; Bozarth, 1996; Wilkins, 2003; Merry, 1999). Rogers (1957) view was that techniques are useful only if they serve as a channel for the core conditions and Merry (1999, p. 116) stresses that techniques are only person-centred when the intent to offer them emanates from the client's inner experiencing.

Many of the criticisms of person-centred brief therapy centre on issues of power and control and echo the current debate from within the person centred community about what it means to be directive and how much intervention can legitimately be called person-centred. Yet as Tudor (2008) points out, such criticisms also suggest a lack of trust in the client, ignoring his capacity for self-determination and his ability to respond to any time limits.

Tudor (2008, p. 15) refers to Rogers' expression 'moments of movement' in which change happens in a moment. This is a reference to time but not to time limits and reaffirms the self-authority of the client. Research by Timulák and Lietaer (2001, p.72) supports this view. They analysed positively experienced episodes in brief person-centred counselling and identified moments of empowerment, which they equated with the "potential for deeper therapeutic engagement in the therapeutic endeavour."

I will now turn to an exploration of the purpose of assessment in therapy and in particular for brief therapy.

Assessment for therapy

Sharman and Seber (2004), writing for the *British Association for Counselling and Psychotherapy* (BACP) in their guidelines for best practice of counsellors working in the NHS, stress assessment as a vital stage providing an opportunity to consider if the client is suitable for counselling, to identify the approach to be used and the duration of therapy.

Brief counselling is not considered suitable for all clients and many authors list those circumstances when it would not be indicated. These include those with chronic drug and alcohol addictions, personality disorders, serious, long standing mental health issues, chronic obsessional or phobic symptoms, those unwilling to accept responsibility, those with extensive personal growth agendas (Dryden & Feltham, 1992; Feltham, 1997). The Department of Health (DH) guidelines on *Treatment Choice in Psychological Therapies and Counselling* (DH, 2001, p. 2) state: "Therapies of fewer that eight sessions are unlikely to be optimally effective for most moderate to severe mental health problems". Casemore (2002, p. 7) considers it unethical to offer counselling unless a rigorous assessment and diagnosis has been made to determine whether "realistic outcomes for the client can be achieved in six to eight weeks."

There would appear to be strong arguments against offering brief therapy to all and this suggests that not only is it important, but an ethical imperative, to assess for duration of counselling. The person-centred counsellor again faces a paradigm clash with issues of power and expertise at its centre. How does she manage this tension?

A reading of the literature on assessment, however, suggests there is no common formula. Milner and O'Byrne (2004) review assessment from different theoretical perspectives including person-centred and comment on the lack of a coherent framework. They suggest this is because counselling is a highly individual activity whose purpose is difficult to define. They report the "feeling" factor, the counsellor and client's "comfortableness" with each other, building positive expectations about the process and the development of a therapeutic relationship as being important.

In the context of brief therapy, Dryden and Feltham (1992) state assessment is important to discover if the client has well defined concerns and goals, to discover her social supports and quality of previous relationships and to assess the stage of change. Hudson-Allez (1997) and Parrott (1999) add that assessment is an opportunity for clients to sample a counselling session, to decide whether they want to engage and to consider their expectations. For the counsellor, they describe assessment as an opportunity for the counsellor to orientate herself to the presenting problem, consider

if the client is an appropriate candidate for brief work, assess level of motivation, emotional strength and whether expectations are realistic.

Hatcher, Huebner and Zakin's (1986) research, however, into short-term psychotherapy suggested that the focus of therapy changed over time. Furthermore, Mace (1995, p. 6), states that although it may be the primary task of assessment to predict the likely course of therapy and outcome, such predictions are far more accurate following a few sessions of therapy. Several authors also view assessment as something that should be happening throughout the counselling contract, not as a one-off event (Bohart et al., 1997; Hudson-Allez, 1997; Parrott, 1999; Scott, 2004). Heyno (2007) writing of her experience of working in an organisational setting, found extended assessments useful because she felt it was difficult to assess how a person could best be helped from the first session alone.

Research by Renk, Dinger and Bjugstad (2000) demonstrated that therapy duration was predicted more from the experience of the therapist than client psychopathology and Hatchett's (2003) study also suggested there was no substantial relationship between psychopathology and counselling duration. Valbak's (2004, p. 174) review of research into suitability for brief therapy concluded there were no single factors that might predict suitability and moreover it was unlikely to expect there was a 'golden predictor' or scale that could indicate which clients would benefit from which therapy.

Research by Chiesa, Fonagy and Bateman (2007) investigated the differences between patients assessed for NHS primary and secondary care services and found that although there were differences with regard to severity of symptoms there were also similarities. Their data pointed to persistence of symptoms rather than severity as indicator of the care pathway.

From this cumulative body of research one may conclude that Valbak's (2004) argument has strong support. This suggests a move away from a modernist to a postmodern philosophy, which challenges the possibilities of absolute truths and the assumption that assessment is both ethical and essential.

The current trend toward using questionnaires and for evaluation of risk or mood, is discussed by Milner and O'Byrne (2004, p. 11) who observe that some counsellors may be reluctant to use data gathering tools because of the fear of clients becoming labelled. They view such measurement as important to establish problem severity but stress the importance of using these tools in a way that is meaningful for the client as an individual with unique problems and solutions.

The literature on assessment indicates there is a broad range of views as to what constitutes assessment with no clear definition as it is interpreted differently according to the theoretical orientation of the therapist. From within the person-centred community there is further debate. It is to this that I now turn.

The person-centred view of assessment

The paucity of person-centred literature relating to assessment indicates its lack of relevance for most person-centred practitioners. There are even fewer references to assessment within a brief therapy setting.

Person-centred counsellors tend to react badly to the concept of assessment as it is considered synonymous with the medical model of diagnosis and formulation of treatment. Most would consider this to be antithetical as it shifts attention away from the client to some theoretical label placing the therapist in the role of expert and not necessarily reflecting the needs of the client (Merry, 2004; Wilkins, 2005). Barnsley (2005), a person-centred counsellor, in her letter sent as a response to Jayne's (2005) article on assessment suggests she would prefer to skip the process. With the focus on the quality of the relationship between therapist and client, as Mearns (1997, p. 91) states, "the assessor would have to make a judgement not only about the client, but on the relational dimensions between the client and counsellor."

Bozarth (1998, pp.125-131) includes a chapter on person-centred assessment and although he states that psychological assessment runs counter to the underlying assumptions of person-centred theory, he states that under certain conditions the use of assessment tests can be justified. Three conditions are considered: when the client requests to take tests, when the organisational setting requires it or when the test may

provide an external referent for a decision facing the client. However, the overarching consideration for any activity, he states, is that the self-authority of the client is honoured. Rennie (1998) from the experiential wing of the person-centred approach, while acknowledging the shift of power from client to counsellor, also suggests some information may be important and counsellors should not rigidly refuse to assess.

Where assessment is mentioned in the person-centred literature, the emphasis is not on tasks and goals to be achieved, but on aspects of the relationship and whether Rogers' (1957) "six, necessary and sufficient" conditions are present (see Worrall, 1997). Toal (2001) considers the goal is to create an environment where the client's actualising tendency can be facilitated and that it is the client who decides whether brief therapy is appropriate, not the therapist. Ansell (2003) considers her current caseload, physical and emotional wellbeing, client's presenting issues, ethical and practical considerations. All of these indicate whether she will be able to offer the core conditions to her clients.

Tolan (2003, p. 135) argues that certain "judgments must be made" as to "Can I work with you? Can you work with me?" and that there may be occasions when the counsellor makes the decision that she cannot work with a particular client. Bryant-Jefferies (2003, pp. 6-7) does not offer a lengthy assessment and states, "assessment is an ongoing process" because clients change over time. He stresses person-centred counselling is not about symptom management or treatment for specific conditions but about offering a facilitative therapeutic relationship. The only goal of therapy is that which the client brings.

Wilkins (2003) cites McMahon's assertion that some subjective evaluation of the client and his needs by the counsellor is unavoidable. He agrees that assessment from the perspective of diagnosis and treatment plan is 'ridiculous' as Mearns (1997, p.91) suggests. However, if the therapist's intent is to form a judgment regarding whether she can offer the core conditions, and this is perceived as such by the client, then the person-centred attitude is honoured.

The contributors to Tudor's (2008) book discuss brief therapy in a variety of settings but it is of interest that assessment receives very little attention. Tudor (2008, pp. 22-26) presents a short section on assessment and argues against selection criteria as these are service led and not client-centred. He presents Rogers' view of diagnosis as ongoing in the experience of the client and one of self-assessment for the therapist to determine whether she can hold the attitudinal qualities necessary for therapeutic change.

The most relevant piece of research was that of Wilkins and Gill (2003). Comparing the initial assessment session, of person-centred and psychodynamic therapists they found there was no real difference between the two orientations in terms of the process of initiating client work. The key difference was in terms of the theoretical constructs used to describe the process. They proposed a theory of assessment that centres on features of the therapeutic relationship and suggest the "necessary and sufficient conditions" (Rogers, 1957, p. 96) be understood as a series of questions a responsible therapist must ask herself at the beginning (and throughout) the process. They also suggest Rogers' (1961, p. 132) "seven stages of process" provide a guide for when and for whom therapy is appropriate. This is an indicator of the client's process in the continuum of personality change from "fixity to flowingness" (Rogers, 1961, p. 132-158). Rogers describes a process of loosening of feelings from being remote and not present in the client's awareness to the client living freely in the fluid process of experiencing and using this as a referent for his behaviour. In stages one and two it is unlikely clients will stay in therapy. Stage three, characterises the stage at which most would enter therapy with most of the work of psychotherapy happening in stages four and five. Stage six, is described as crucial and irreversible and leads into stage seven.

Wilkins and Gill's (2003) contribution to the debate is useful as it provides the person-centred practitioner with a theoretical framework in which to locate the assessment process using the language and concepts of the person-centred paradigm. Their study also highlights once again the difficulty with language and interpretation and engages with the current debate within the person-centred community regarding directivity and the locus of power and control.

Wilkins (2005, p. 131) highlights the different cultural views with regard to assessment and diagnosis within some quarters of continental Europe where person-centred practitioners do not see it as problematic. Here person-centred research has increasingly become more 'disorder specific' and the language of psychiatry and medicine may sit more comfortably than in the U.K. In the U.S.A. too, the influence of psychiatry has grown. Hansen (2003) reported how diagnostic training was already being assimilated into humanistic counselling training programmes and observed how such trends would threaten to undermine the identity of the profession as a whole.

Although Rogers (1951) did not discuss assessment, he did refer to diagnosis stating it was unnecessary, unwise or even detrimental, because it places the locus of evaluation with the therapist as expert and because of long range issues of social power and control (Rogers, 1951). He stated, "therapy is diagnosis and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician" (p. 223). Schmid (2003) also argues against diagnosis stressing that person-centred diagnosis is a phenomenological process "unfolding step by step through the joint process of experiencing and reflecting by both client and therapist."

The *Symposium on Pyschodiagnosis*, first published in the *Person-Centred Review* in 1989 and reprinted in Cain (2002) highlights the arguments for and against diagnosis. The debate echoes many of the arguments regarding assessment and often the terms appear confused. This debate is as alive and relevant today (see also Freeth, 2007, a psychiatrist and person-centred therapist, who discusses diagnosis, assessment and the medical model). At one end, there are those who vehemently oppose it, at the other there are those who see it as a reality and that sometimes it may be useful. Wilkins (2005) argues that diagnosis is different from, although a possible product of, assessment and points out that it is the conflation of the terms assessment with diagnosis that seems to cause much of the debate.

Conclusion

The literature highlights the contentious nature of the issue of assessment for person-centred practitioners. It divides and challenges the community as it strikes at the heart of deeply help beliefs and attitudes about the locus and nature of power and control.

However, it also indicates there is a process of subjective evaluation going on in the experience of the counsellor. This refers to aspects of the relationship, and whether the counsellor's attitudinal qualities, indicated by Rogers (1957) can be met. According to Wilkins (2005), this may be called assessment even though many would resist using the term. The person-centred approach challenges the conventional view of assessment as defined by authors from other theoretical models and it seems clear that there may be a difficulty with the language used and interpretation of the term assessment.

There is a lack of research or literature to support or guide the person-centred counsellor and until recently, very little has been written about assessment within the context of brief therapy. It feels timely, therefore, to provide further research that will inform the counselling world in general and person-centred practitioners in particular, so there may be a greater understanding and sympathy across modalities. The person-centred practitioner may then feel more confident about defending her approach in a world that demands more accountability and speedy delivery of services.

CHAPTER THREE

METHOD

Philosophy and research design

In considering my research method I was aware of the ideological tensions that existed for me from both a professional and personal perspective. Quantitative (old paradigm) methods follow the positivist, scientific view of a single, knowable, objective reality or truth with one best way of gaining knowledge. Deductive methods, theory testing and measurement are used (McLeod, 2001). Qualitative (new paradigm) methods, however, acknowledge the agency of the person and see the natural, scientific notions of causality as inadequate for an understanding of the human condition. Post positivist approaches give priority to the phenomenon of the person and reality is interpretive, with multiple, contextual and socially constructed meanings (Crothers & Dokecki, 1989).

From my early scientific background and training, measurement and statistical analysis remained familiar, seductive and safe and were valuable research tools. However, I agree with Silverman (2005) that it is unhelpful to think in terms of a quantitative/qualitative polarity. The decision should depend on the purpose of the research, the nature of what the researcher wants to find out, the level of precision required and the resources available.

I was seeking to explore and capture the non-quantifiable; the processes involved and the personal meaning of the events as experienced by the participants. I did not have a preconceived theory regarding what should be happening in the initial counselling session and was not seeking to isolate, quantify and analyse variables. I wanted to acknowledge and recognise the participant as agent and interpreter of the phenomenon, which quantitative methods fail to do (Bohart et al., 1997). Qualitative research, however, uses inductive methods; participants give verbal expression to their thoughts and feelings, with meanings emerging from the data. The outcome

therefore, would not be a generalisation of results but a deeper understanding of the phenomenon (Lincoln & Guba, 1985).

A qualitative methodology fits philosophically with my chosen model of counselling and with that of the participants. The person-centred model is underpinned by phenomenological principles and acknowledges the centrality and uniqueness of human experience. Echoing Kelly's argument (cited in Crothers & Dokecki, 1989, p. 307) that theoretical and methodological approaches to the person must account equally well for both researcher and participant, I felt this philosophical fit was an important consideration. I was not intending to study and measure the participants objectively but to invite them to contribute to the construction of knowledge through expression of subjective meanings and experiences. The qualitative method, therefore, seemed to provide the best fit for my research.

In qualitative research, the subjectivity of both researcher and participants becomes part of the research process with interdependence between the knower and the known (Flick, 2006; Maykut & Moorhouse, 1994.). I had to acknowledge my personal influence in the research as I was already practising within a brief therapy setting. To minimise this and to ensure personal biases and assumptions did not prejudice the process, I engaged in the process of 'epoché' whereby subjective perspectives and projections were bracketed off in order to reveal the essence of the experiences (Maykut & Moorhouse, 1994; McLeod, 2001).

Additionally, acknowledging myself as 'human-as-instrument' with all my experiences, knowledge, skills, and biases, I adopted a posture of 'indwelling' throughout the process of inquiry. I considered this necessary in order to be critically reflexive, accounting for the personal, the subjective and any assumptions I may be bringing to the research (see Maykut & Moorhouse, 1994, p. 25; McLeod, 2001, p. 199). In-dwelling also facilitated the acquisition of 'tacit knowledge' considered necessary for a full understanding of the participant's experiences, as described by Polanyi (cited in Maykut & Moorhouse, 1994, p. 33).

I pursued an emergent design, which allowed me to respond with flexibility and openness as new discoveries and questions emerged from the data. This is a key

feature of qualitative research, whereby there is a broadening or narrowing of the focus of inquiry as the data is analysed early on and throughout the process of the research (Maykut & Moorhouse, 1994).

I considered the path of the *'bricoleur'* (McLeod, 2001, p. 121) in an attempt to identify the most appropriate methodological genre from among the many on offer. However, I was aware of my limitations as a researcher. I did not possess the research skills, expertise or time to engage in *bricolage* and was in danger of becoming confused and overwhelmed by different qualitative methodologies. McLeod (2001) discusses the implications for the researcher-as-*bricoleur* and mindful that my research was a small-scale study, I chose to stay within the boundaries of the more traditional approach to qualitative research and learn from the process.

Equally, in choosing a single methodology I was aware that I would not reach a point of triangulation. Aware that all data is partial, I could not attempt to present the whole picture with a small-scale study, but endeavoured to provide rigour and simplicity at the expense of completeness (Silverman, 2005).

Sample

Quantitative methods may rely upon a large, randomly selected sample to represent the population from which inferences are made. The qualitative method, however, involves the intensive analysis of a carefully selected small sample. Patton (2002, p. 230) suggests purposive sampling using 'information-rich' cases which are chosen to reflect relevant characteristics of the wider group from which results may be generalised.

To secure an 'information-rich' sample I defined the parameters of my sample group as follows:

- **Person-centred counsellors trained to at least diploma level.**
  There is a concern that many practitioners have hi-jacked the term 'person-centred' and applied it to their own, different, theoretical model (Sanders, 2004). To minimise this, I chose to identify those counsellors who had attended a

diploma level course whose core model was person-centred rather than those who attended an integrative course.

- **Person-centred counsellors who defined themselves as essentially purist.**
  Milner and O'Byrne's (2003) study reported that very few counsellors, irrespective of their chosen model, called themselves purist, with eclecticism or integrative becoming the predominant theoretical orientation. It was, therefore, important to establish how the participants defined or described their counselling approach.

- **Minimum of three years counselling experience since qualification.**
  I chose a minimum of three years post qualification experience in order to ensure the participants would have had sufficient time to hone their therapeutic approach and develop their own way of working within a brief therapy setting.

- **Those working to brief therapy contracts.**
  I wanted to identify those participants who worked to brief contracts of typically one to eight sessions rather than those whose work just happened to be short term.

With small-scale qualitative research, variability characteristics cannot be addressed via random sampling. Patton (2002, p. 234) suggests the strategy of maximum variation sampling as one method of addressing this problem. In this way, central themes are of interest as these capture the core experiences of the phenomenon not just the idiosyncrasies of a narrow group (Gerson & Horowitz, 2002). I, therefore, chose to include participants from different organisational settings to minimise the possible effects of organisational pressures or influence upon the counsellor's working practice and used 'emergent and sequential' snowball sampling as described by Maykut & Morehouse (1994, p. 57).

I targeted my sample population by advertising in the BACP journal *Therapy Today,* the magazine for the BAPCA, *Person Centred Quarterly,* used personal and professional contacts within local training institutions and professional networks in my local area (see Appendices 2A & 2B).

Table One: PROFILE OF PARTICIPANTS

Participant no.	**1**	**2**	**3**	**4**	**5**
Gender	F	F	M	F	F
Work setting	NHS & Private	NHS	Voluntary sector	NHS & EAP	NHS
Counselling qualifications & core theoretical model of training	Diploma Person-Centred	Diploma Person-Centred	Diploma & M.A. Person-Centred	Diploma Person-Centred	Diploma Person-Centred
No. of years counselling experience	8	11	7	11	14
Orientation on the Person-Centred scale (1-7: purist – integrative)	4	1	4	5	2
No. of sessions offered	6-8	6-12	10	6-12	10
Initial session offered to decide on brief therapy	Y	N referrals screened by another professional	N referrals screened by another professional	Y	Y
Currently in supervision	Y	Y	Y	Y	Y
Works to BACP Ethical Framework	Y	Y	Y	Y	Y

Owing to the limits of time and resources for completion of this study, I limited my sample size to five. In doing so, I was aware that it was unlikely I would reach a point of saturation of data, which is considered desirable for an emergent qualitative design (Maykut & Morehouse, 1994). Furthermore, the limited responses meant that I was unable to achieve the variance of organisational setting that I had hoped for. Details of the participants used are given in Table One.

Pre-interview questionnaire

I designed a questionnaire to send to interested applicants and from which I was able to identify my sample according to the above criteria. The questionnaire was piloted with a small group of colleagues beforehand and their initial comments helped me to refine the questions and include useful amendments. See Appendix 2C for copy of questionnaire and covering letter to applicants.

I considered a number of ways to establish purity of counselling approach. Asking participants to provide a lengthy justification of their position felt judgemental and would be time consuming and potentially off putting for the participants. To include a set of definitions of person-centredness as suggested by Warner (2000) and Sanders (2004, pp. 149-163) felt unnecessarily complicated. In the end, I opted for a simple rating scale from purist to integrative. Feedback from trials with colleagues suggested that seven was the optimum number of points to use on the scale because it provided sufficient flexibility for participants to identify their position without being too narrow or extensive.

I acknowledge that theoretical purism is perhaps unrealistic and unattainable because individual experience and interpretation shapes the way we work and I anticipated there would be a spectrum of person-centredness mirroring the differences within the 'tribes' of the person-centred family, as articulated by Warner (2000) and Sanders (2004). The need to consider offering definitions at all reflected the existing tensions and current debate with regard to identity within the person-centred community as a whole (see Sanders, 2000).

Those not chosen for interview were sent a follow up letter informing them that their details would be held until the end of the research (Appendix 2D). If my initial criteria had been too rigid, the opportunity to contact other participants later remained an option.

Data collection

I considered the use of questionnaires with open-ended questions rather than interviews, as this would have given me access to a much larger sample. Earlier experiences of using this method, however, resulted in data both limited in depth, with no opportunity to gain further clarification from participants and open to the criticism that questions may be interpreted in different ways. Moreover, a questionnaire would have required asking pre-determined questions based on my assumptions and views of the processes involved during the initial counselling session. This would have introduced an element of researcher bias I wanted to avoid.

Kvale (1996) describes qualitative interviewing as a kind of guided conversation but where there is an absence of preformulated suppositions. The researcher adopts a deliberately naïve stance remaining open to new and unexpected phenomena. The purpose is not to extract facts or laws from the interviewees but interpretations (Warren, 2002). By using interview data with analysable texts I could, therefore, explore the meaning of participants' experience (see Denscombe, 2003, ch. 9 & 10).

I researched several interview methods and was guided by the degree of structure I felt was necessary and how much of myself I felt I was bringing to the research.

Structured interviews appeared to resemble a spoken questionnaire and I did not want the rigidity of pre-set questions, which might lack the flexibility and sensitivity to context, required for interpretation of personal experience (Mason, 2002; Siedman, 1998). I considered the heuristic method (Moustakas, 1990) but rejected this because it would be too autobiographic. Although I acknowledge that the choice of research topic has personal significance for the researcher, whether conscious or not, and the researcher may project, out of awareness, her own internal problems (Etherington,

2004; Reason & Rowan, 1981) I did not want my story to be a major part of the research. I wanted to hear others stories and look for common threads and meaning.

There were two relevant questions: what was the purpose of the interview and what was I trying to understand?

My purpose was to explore counsellors' experiences and the meaning they made of that experience and to understand the processes involved when decisions were made regarding the suitability of person-centred therapy as a helpful intervention. I wanted to remain as open as possible to the counsellors' personal accounts, to the way they made sense of the initial sessions with a client. I decided, therefore, to situate the interviews within a broadly unstructured framework, as this is considered more appropriate for research involving an exploration of personal accounts and internal experience (Denscombe, 2003; Silverman, 2005,).

Using the term, 'unstructured', I agree with Mason (2002) that it is not possible to conduct a completely structure-free interview because of the framework imposed by the researcher's agenda. It is a question of degree and on the structured-unstructured continuum, I chose the unstructured end of the scale. Following presentation of the research question, I framed a single opening question as described by Maykut and Morehouse, (1994, p. 82) but then gave each participant the freedom to develop their own ideas and thoughts. My aim was to maintain a balance between being obtrusive and unobtrusive; to intrude as little as possible but to balance this with the need to avoid an overabundance of data (McCracken, 1988). Furthermore, I did not impose a time limit on the interview but allowed the process to run its natural course.

I also prepared a number of prompts as an 'aide memoir' to ensure specific issues relating to organisational constraints, assessment and referral pathways were covered by all participants and to provide a focus for the interview (Appendix 2E).

I acknowledge that I was not a detached interviewer and my influence on the resulting data became a product of both participant and myself the researcher, as discussed by Fontana (2003). I also agree, however, with Gubrium and Holstein, (2003, p. 34) that it is realistic to regard all interviews as 'interactional', as a "discourse between

speakers" and even minimal, token responses cannot be eliminated or the conversation and hence the interview, ceases. The primary focus, however, was on the participant's experience, not mine, as discussed by Seidman (1991).

I conducted a pilot interview with a colleague in order to gain feedback on the interview process and my interview style. This was useful as I was aware of how involved I was in the research and helped me to bracket off my agenda and become more detached.

Prior to interview, I sent each participant two copies (one to keep, one to return) of the University of Chester's Consent Form for the audio recording of the interview, (Appendix 2F) together with a copy of the interview question and a covering letter detailing issues of confidentiality for the transcribed data (Appendix 2G).

I interviewed participants at a venue of their choosing and all were digitally recorded and transcribed verbatim. Warren (2002) points out that unrecorded data is as important as recorded data and following each interview, I made supplementary notes to complement the audio recordings.

Data analysis

In qualitative research data analysis and collection of data often runs parallel. Richards (2005, p. 6) describes the process as 'looping' where the researcher learns from the data and then returns to revise or revisit earlier steps taken. I adopted Moustakas' (1990) heuristic approach of immersion in the data, which began during the process of listening to and transcribing the interviews. Following transcription of each interview, I contacted each participant inviting them to read the completed transcript and to make any corrections or alterations before I began data analysis.

I used the constant comparative method of data analysis adapted from Grounded Theory, as described by Maykut and Morehouse (1994, pp. 127 - 149) which involves a systematic analysis so that concepts and categories can emerge inductively from the data. This involves a process of deconstructing, or pulling apart of the data, to extract

the meaning and then reconstructing it in a way that is meaningful. Appendix 3A provides a detailed account of the analysis process. A summary is presented below.

To open up the data for the analysis I continued with the process of immersion, reading and re-reading the transcripts, questioning, making comments, looking for ideas that might lead me to themes and concepts. I kept a 'discovery sheet' (Maykut & Morehouse, 1994, p. 133), which recorded my thoughts, recurring themes and patterns. I made space during the day in which I could focus on the data, allowing ideas to germinate and kept a research journal in which to chart my thoughts and feelings throughout the process (see Appendix 3B for journal notes relating to transcript 5).

Different units of meaning from the data were compared then grouped into provisional categories, which were coded. These provisional categories were later refined as new categories emerged and I developed 'propositional statements' (Maykut & Morehouse, 1994, p. 140) which reflected the collective meaning for each category. I then looked for patterns and relationships across the categories so that the data could be integrated and reconstructed into a new synthesis (see Appendix 3C for a list of units of meaning relating to two provisional categories and Appendix 3D for a complete list of all propositional statements and categories.)

This process of analysis required lengthy periods of waiting and patience, a time of incubation before insights were gained. I was also aware of how much I was part of the research. The interviews and data were collaborative constructs between the participants and myself. Strauss and Corbin (1998, p. 43) discuss the problems of immersing oneself in the data while still maintaining a balance between objectivity and sensitivity. Without sufficient sensitivity subtle nuances, meanings and connections in the data might not be perceived. Without sufficient objectivity my own biases, assumptions and beliefs might contaminate the data. To minimise researcher bias I attempted to remain as open as possible, taking care not to filter out or minimise any data because of any previously held assumptions.

Validity

In quantitative research, statistical tests can be applied to measure the truth value, reliability and objectivity of the data. For qualitative research, this is not as straightforward as there are no tests that can be automatically applied. Qualitative interviews are often criticised because they lack objectivity leading to different researchers finding different interpretations of the same interview. Postmodern understanding, however, assumes the co-creation of knowledge, which is culturally and historically situated and allows legitimate plurality of meanings (Kvale, 1996). To be accepted as trustworthy and to have wider relevance within the counselling community, it is important that qualitative research can counter the charge of subjective bias and account for the claims being made (Reason 1988). The question of validity or trustworthiness in qualitative research, therefore, refers to how the data is produced, how it is presented and how the inferences are drawn (Flick, 2006).

Following McLeod's (2003) criteria for evaluating validity, I have proposed a research study that has particular relevance within contemporary counselling practice and comprehensively explained the research methods employed, the selection of participants, how data was obtained and how analysed. There is a complete audit trail of the research process so that the routes taken, methods used and decisions taken can be tracked and explained.

To minimise my influence on the interview process, I did not interrupt or divert the flow of dialogue but allowed participants to develop and reflect upon their ideas and understanding of their experience. 'Member checks' (Maykut & Morehouse, 1994, p. 147) involved showing the interview transcripts to the participants to confirm accuracy.

The method of data analysis involved comprehensively inspecting and comparing all parts of the data to minimise subjectivity and possibly biased data selection (Silverman, 2005) and I have engaged in the process of 'epochè' (Patton, 2002) in an attempt to minimise personal biases, prejudices or assumptions, which might influence the research phenomenon. I also searched for rival or competing themes and explanations for the data that might lead to different conclusions (McLeod, 2003).

Within the limits of this small scale study I endeavoured to vary my sample as much as possible to ensure the findings were not an idiosyncratic result of a single case or cases from the same organisation. However, I accept that the variance achieved was less than ideal.

By adopting a critically reflexive stance (McLeod, 2001), I applied self-awareness to the research process. This involved a reflexive exploration of inward subjectivity but also being aware of (external) local, contextualised knowledge and influence. Regular discussion of the process was augmented through contact with my research supervisor and counselling colleagues. As recommended by McLeod, (2003) I kept a research journal recording my reflections of the inquiry process; my thoughts, ideas, assumptions, theories and changes throughout each step of the project. Acknowledging my personal interest and connection with the research topic, I have endeavoured to remain as open and transparent as possible.

Ethical considerations

All participants were volunteers and practising counsellors. In considering the possible consequences of taking part in the research, I felt it was unlikely to cause distress to the participants. However, I was also aware that there are risks and benefits to every interviewee (Kvale 1996), and sought to minimise any possible harm this might cause.

As a practising counsellor and member of the BACP, I accept and am bound by both the *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP, 2002) and the *Ethical Guidelines for Researching Counselling and Psychotherapy* (Bond, 2004). By adopting the recommendations in these guidelines, I am asserting my intention to operate with honesty, integrity, beneficence and nonmaleficence towards the participants in my research, the profession of counselling and the research community in general.

All the participants were given consent forms beforehand and the option to withdraw from the research process at any time. I gave them a written statement of the research

aims and procedures before participating and details of whom to contact if they had any concerns or complaint to make as a result of their involvement in the research.

I faithfully transcribed each interview, following which, I contacted each participant giving them the option to read the full transcript so that deletions or inaccuracies could be remedied and portions of the data removed. Upon completion of each transcript, I erased the digital recording and stored all research data safely and securely.

I guaranteed the anonymity and confidentiality of participants, being careful not to include long sections of transcript material and removing any content from the data that might compromise their identity. My methods and parameters used to protect confidentiality have been made explicit to the participants as determined by my professional code of ethics.

In consideration of any possible harm that might occur to the participants, I ensured all were in ongoing supervision to mitigate against any possibility of distress arising from participation in the study. Where necessary, I made use of my counselling supervisor to reflect upon and seek advice on the process.

Before beginning the research, I submitted a research proposal to the University of Chester's Department of Social and Communication Studies Ethics Committee for their scrutiny and approval. I also remained in regular contact with my research supervisor who monitored and offered guidance throughout.

Limitations of the research

Limits to time and resources precluded a larger sample and hence this could only be a small-scale study raising the question of how far the results can be generalised to a larger population. Sufficient variance of organisational setting was also less than ideal. There is an imbalance towards counsellors working in the NHS although this may reflect the current trend toward brief therapy within healthcare settings. The trustworthiness of the data could be enhanced if the sample size was increased until saturation point was reached (Strauss & Corbin, 1990).

In choosing a single methodology, I was aware that I would not reach a point of triangulation (Patton, 2002; Denscombe, 2003). Multiple methods of data collection such as a combination of questionnaires and interviews might have added to the trustworthiness of the data. I also acknowledge the interviews were a product of myself the researcher, and the participant. The transcripts became decontextualised conversations (Kvale, 1996) which were then broken down and coded according to my interpretations. West (2001) questions whether anything is lost in this process. Using additional researchers would help to remove single researcher bias.

However, I question whether it is realistic to assume that alternate perspectives generated from different methods can be aggregated to generate a more complete approximation of the social world. As Coffey and Atkinson (1996) point out, it feels more realistic to assume that different research methods will yield different versions of the social world but this only serves to reveal its complexity.

There can be no single conclusion because, as Coffey and Atkinson (1996) argue, there is no single point of reference, no reality independent of our constructions of it. We can only construct partial views of reality but this does not imply they are imperfect. Triangulation then becomes an alternative to, rather than a strategy of, validation (see also McLeod, 2001, p. 188). In considering the gains and losses of using triangulation, I agree with Patton (1990) that with limited time, it may be preferable to adopt one approach well rather than use several poorly implemented methods.

In seeking to use person-centred counsellors, I acknowledge that it was difficult to ensure purity of approach, as Milner and O'Byrne (2003) discovered. The research outcomes may reveal differences due to the different interpretations of what it means to be person-centred and this may be impossible to measure. Nevertheless, the outcomes do represent the perceptions of those who call themselves person-centred.

The influence of the culture and ethos of the organisational setting cannot be ignored. In a healthcare setting where the prevailing culture is the medical model of diagnosis and treatment, there may be a greater pressure to conform to this culture and to

change or adapt the counselling approach accordingly. The sample was weighted towards those counsellors who worked in the NHS and it is difficult to assess at this stage how much the results were influenced by idiosyncratic differences pertaining to this organisational group. Further studies could expand upon this data by actively seeking counsellors from other organisational settings.

The use of interviews for data collection assumes the centrality of talk and text for our ways of knowing about the social world (Mason, 2002). It is important to consider how useful interview data can be in giving direct access to experience where so much of this experience may be out of awareness, or has become so familiar it is at an unconscious level (Silverman, 2005). I accept that the research data can only give a partial view of the process of assessment. My intention, however, was not to seek an illusory whole truth but to explore in greater depth a little more about the processes and personal meanings for my participants.

CHAPTER FOUR

RESEARCH OUTCOMES

This chapter presents the themes and categories that emerged from the data analysis. Preliminary coding yielded twenty-two separate categories for which I assigned propositional statements of rules for inclusion. Further examination of the relationships and patterns between them revealed four main themes as shown in Table Two. Please refer to Appendix 3D for a comprehensive list of all twenty-two categories with their propositional statements.

The four main themes and categories are presented in more detail together with quotations from the research participants, thus allowing their voices to be heard. Each section of transcript is referenced in brackets by the participant number P1 to P5, together with the page number of the transcript, T1, T2 etc. For example (P1:T1) refers to participant one, transcript one. Where quoted, the researcher is referred to as 'R'. All quotations are verbatim except where specific details have been changed to protect confidentiality and anonymity of the participants. Where the transcript was inaudible this is indicated by three unbracketed dots, where several lines have been omitted this is indicated by three bracketed spaced dots (. . .).

Table Two: SUMMARY OF MAIN THEMES AND CATEGORIES

THEME	SUB-CATEGORY
1.0 Counsellors' phenomenology of working within a brief therapy model.	1.1. Counsellors' positive attitude towards brief therapy. 1.2. The influence of the brief therapy model on the client's process. 1.3. The influence of the brief therapy model on the counsellor's process. 1.4. Client's readiness for counselling. 1.5. Tensions arising from organisational requirements in the first session.
2.0 The person-centred relationship in brief therapy.	2.1. Being person-centred. 2.2. Process of building a relationship. 2.3. Trust. 2.4. Influence of the CBT model
3.0 How person-centred counsellors conceptualise the process of assessment.	3.1. Meaning of the word assessment for the counsellor. 3.2. The process of assessment. 3.3. Counsellors' intra-personal experience. 3.4. Counsellors' experience. 3.5. Client autonomy. 3.6. Emergent process of assessment. 3.7. Contracting.
4.0 Managing brief therapy.	4.1. How clients are referred to the counsellor. 4.2. Referral pathways for the counsellor. 4.3. Accepting all clients for counselling initially. 4.4. Options to extend therapy. 4.5. Importance of the first session (as the beginning of the therapeutic relationship). 4.6. Counsellors' use of supervision.

THEME 1.0

Counsellors' phenomenology of working within a brief therapy model

This heading includes five of the original categories and describes the participant's experiences of working within a brief therapy model; their attitudes, perceptions and the tensions.

1.1 Counsellors positive attitude towards brief therapy.

All the participants reported positively about being able to work in a brief therapy setting although counsellor P4 also stated that it might not work for everyone.

> *So having a time limit on it in my experience, you know, I don't see it as always being a negative thing. I think it has got some very positive aspects.(. . .)But like I said before, I suppose for some people it's not going to work for everybody. You know, that limit.* *(P4:T13)*

> *I don't see it as 'this is all we've got'. I see it as this is what we've got, we've got this time and it's actually a lot ....I don't see it as limiting and second best.* *(P2:T14)*

> *My philosophy is being heard and being taken seriously and being valued in ten sessions, is better than not having that experience at all..* *(P5:T2)*

Counsellor P2 felt that the counsellor's positive attitude was important to ensure the client felt motivated to work:

> *I think the ability to work in this way is an attitude. If you have an attitude of 'oh well this is second best and it's all we've got, it's not very much and I'm really not sure we're going to get very far in this time', this will become apparent to the client. Whereas, if you go into like 'we've got all this time, you get stuck in and we'll do this, you know, trust me we'll get somewhere, I don't know where we'll get but it will be somewhere', that will rub off on the client and that will give them confidence and hope.* *(P2:T14).*

While acknowledging much could be achieved in six sessions, counsellor P1 still felt that it was not a great deal of time:

> *But I do find, having worked with long term psychotherapy and short term, a lot of the work is done in the first few sessions. However, I do feel that six is very brief.* *(P1:T1)*

1.2 The influence of the brief therapy model on the client's process.

Some of the counsellors felt that working within a brief therapy model positively affected the client's process by motivating them to get on with the work:

> *There is not a lot of time. So people have to know that and work very, very hard.* *(P2:T11)*

If you say to clients "we offer a maximum of six sessions", they move on very quickly themselves. They think, oh golly, I've only got six sessions, I need to crack on with this. *(P1:T16).*

So they realise that it's not an endless relationship that will go on until they just happen to feel better. *(P3:T12).*

1.3 The influence of the brief therapy model on the counsellor's process.

The participants reflected that the time limit affected their process too. Being mindful of the time, their work became more focused.

When people need counselling they need it now and there is a little bit of urgency comes into it because we've only got 12 sessions and we've got to work quite hard and we've got to work towards that time. *(P3:T15)*

We are very focused and mindful of the fact that we don't have a long time and so everybody develops a way of helping the client. *(P2:T12)*

I am probably actually different now in my first sessions with clients to how I would have been a couple of years ago. That process is...there is a lot more going on in my mind, 'cos it's brief therapy thinking ...what things are we going to do to get this person from A to B? *(P4:T3).*

In there, right from the beginning. So it's much more interactive. I mean I'm much more active in the relationship. *(P2:T19)*

1.4 Client's readiness for counselling.

Participants also reported that a key factor in determining the effectiveness of brief therapy was the client's readiness for counselling. The counsellors felt that when their clients were ready to engage with the process they worked hard during the sessions.

Clients, in my experience, quite often if they're in the right place and ready to do the work, will do it because they know it's in that limited time. *(P4:T13).*

Sometimes they'll stop coming and then maybe one year or two year's later we'll get a re-referral to say this person did attend but stopped because they didn't think it was being helpful, but they now feel ready to address their issues. *(P2:T12)*

A lot of the client's come ready to trust me because they've jumped through so many hoops and they've waited so long for this. It's like, 'right, let's go, I want to do it'. *(P2:T18)*

1.5 Tensions arising from organisational requirements in the first session.

Many of the counsellors reported the tensions they experienced from working within a time limit. Sometimes this was because of an organisational requirement to complete assessment forms:

If we do the risk questions as well. That's the bit I hate doing in the assessment process because again I'm standing in judgment with this piece of paper that people have filled in and they are looking at me, you know, wondering what, seems like wondering, 'what is she thinking?'. I don't like that. *(P5:T10)*

I wouldn't be asking those questions if it wasn't for those forms. *(P4:T7)*

At other times, it was because organisational protocols determined certain exclusion criteria for brief therapy and the participants could not offer counselling even though in other circumstances they would do so. Referring to referrals for new clients who fell within the exclusion criteria, counsellor P5 commented:

That's another dilemma when it has sexual abuse on because I've worked with....and I know that people can do it in one, two and it may be one hundred and two. But the words sexual abuse don't automatically mean that it's going to be long term work. *(P5:T6).*

I find it very difficult because really I am willing to work with this person. *(P5:T3).*

Counsellor P1 echoed similar feelings:

I suppose initially I felt quite restricted with that and sort of felt it was unfair for the client. *(P1:T1)*

Counsellor P4 spoke of the tensions of having to refer clients back to the referrer.because the presenting issue fell within the exclusion criteria:

> *It's hard to say 'no' yeah and send them back. Because I know that sometimes they may be left for months without anything. That doesn't feel right.(...)That's a bit of a battle for me and that it's political I suppose as well as emotional.* *(P4:T12).*

THEME 2.0

The person-centred relationship in brief therapy

This includes four of the twenty-two categories and reflects how the participants described their 'way of being' with clients and how they developed a therapeutic relationship.

2.1 Being person-centred.

The person-centred core conditions of empathy, acceptance and genuineness were seen as essential for the client to move along with the work of counselling and all of the participants felt that, within the constraints of the service, i.e. time boundaries and form filling, this way of being was not compromised.

> *They are there: the acceptance, the respect, the non-judgmental approach, these are things which are so built into me that that's where I start.* *(P3:T8)*

I don't think I've ever yet reached the view that my general person-centred approach as such, is not going to be appropriate. *(P3:T9)*

I definitely work with the person-centred theory. That's me, it feels right for me. *(P1:T14)*

I strive to be as person-centred as I can within the constraints of the service and also try to provide the core conditions to the best of my ability and I think that it is possible to do that. *(P5:13)*

Counsellor P2 stressed that her way of working was no different whether working short or longer term:

We do see people longer term(. . .) and I don't work any differently there. That's what other counsellors say. They don't actually work any differently, short term or long term. *(P2:T17)*

2.2 Process of building a relationship.

The participants reflected on the process of therapy with their clients and stressed the importance of building a working relationship as quickly as possible.

When asked if this was different from working long term, counsellor P1 stressed there was no difference.

R: That process happens in the same way? It's not more quickly or less quickly?

P: No(...)I'd hope within the first session to build that rapport straight away really. *(P1:T16)*

Counsellor P1 felt that the person-centred attitude facilitated the creation of a strong therapeutic relationship from the beginning.

I think the relationship that we build within the first few minutes is, some counsellors from different schools of thought take a lot longer than that to build up. *(P1:T15)*

Counsellor P2 stated:

I do it by offering the core conditions as intensively as I possibly can. *(P2:T19)*

Counsellor P4 explained

I do engage from the beginning (...) I am assuming they are wanting to start forming a relationship with you because that's what they are here for and they are here to be heard and start doing some work. *(P4:T18)*

2.3 Trust.

Many of the counsellors used the word trust when describing the process of building a therapeutic relationship.

For me the empathy, particularly in the first session is key to them beginning to trust me. *(P4:T2)*

She said "I've got to the stage now where I trust you so much that I think I can tell you about it." *(P3:T6)*

Counsellor P2 stressed that with limited time it was important for the client to be able to trust straight away, so the work could begin. There was no time for a lengthy beginning phase that might take several sessions:

I don't have the luxury of building up a relationship of trust. I don't have that beginning phase, you know that Thorne writes about in Person-Centred Counselling in Action. It has to take minutes rather than weeks (. . .) They have to trust me straight away. *(P2:T18)*

2.4 Influence of the CBT model.

Reflecting on their person-centred stance, some of the counsellors had received some training in CBT and spoke of how this might inform and influence their work.

I am very person-centred and if I use CBT it is in a very person-centred way. *(P1:T13)*

I don't say well I'm going to move onto CBT now and I'm going to move onto gestalt now. It's just something which comes quite naturally with the way of discussion where the client goes. *(P3:T9)*

Counsellor P4 also acknowledged that CBT techniques would only be used if she felt.this would be appropriate for the client:

> *They wanted, were specifically wanting and it was very much CBT type interventions, (. .)so because I'd got that CBT course under my belt more or less I did use that"* *(P4:T4)*

THEME 3.0

How person-centred counsellors conceptualise the process of assessment

Seven categories referred to the concept of assessment, counsellors' understanding of this as a process and their experiences in the first session with a client.

3.1 Meaning of the word assessment for the counsellor.

When asked to consider their understanding of the word 'assessment', it was clear this was not a word the participants used readily. One of the counsellors (P1) referred to the first session as the assessment session because that was how it was defined by the employing organisation. Others simply referred to it as the first session and referred to what it meant to their employing agency or to what other professionals might expect it to mean:

> *Well it's not assessment in CBT terms.* *(P3:T6)*

> *I've taken it from my employer as, not from me as a person. I think it's very much tied up with forms and ticking boxes.* *(P4:T4)*

> *Assessing is kind of to me, ticking boxes, asking questions, and I don't do that.* *(P5:T8)*

It was also felt by some that the word assessment implied power or passing judgment on the client:

> *I had one session with this woman which was really an assessment and I really hate that word as well, 'assessment' but I do have to do it.* *(P5:T2)*

> *I'm sitting, standing in power over this person, aren't I? Giving the yes or no as to whether they can access counselling or not and I just, I'd rather trust them to know.* *(P5:T6)*

> *So assessment maybe means me making a judgment about the clients and about the clients presenting issue.* *(P4:T4)*

3.2 The process of assessment.

All the counsellors summed up their experiences of the process in the initial session in similar ways: they tried to understand and learn about the client. It was regarded as the beginning of an exploration of whether counsellor and client could work together and whether counselling would be appropriate and helpful for the client. The counsellors would try to engage with the client's experiencing and help them to engage with the process.

> *I see assessment in terms of what will help this client.* *(P2:T15)*

> *I see it as an exploration to see if you want to work with me, to see if I am happy to work with you, see if we can get on together.* *(P5:T6)*

I think I really regard the first session in simple language – getting to know you. I'm getting to know you, trying to understand what you're saying, trying to understand what the problems have been, trying to empathise to the extent that I can with what you are telling me so that I can have a better understanding of what you've been through, what you've suffered. *(P3:T8)*

I suppose for me all it is if I felt I couldn't work with the client or the issues were beyond my competence. *(P1:T11)*

I think the biggest question that I try to bear in mind possibly throughout my work, but certainly in that first session really, does feel really important is: am I understanding this person's world from their point of view, am I kind of getting into their frame of reference, and am I feeding that back to them so they can see that I am getting into their frame of reference or at least trying to? And that being very accurate. *(P4:T8)*

Some of the counsellors also used the words 'psychological contact' to describe the process:

Again the psychological contact and or this feeling of not being able to get into their frame of reference. *(P4:T11)*

Well I guess if I'm feeling that I'm in psychological contact in Rogers terms. *(P5:T12)*

Referring to a difficulty with one client in the first session, counsellor P4 said:

We didn't have one of the six core conditions. That we weren't in psychological contact. He was unable to be in psychological contact with me, through no fault of his own, and I was unable to be in psychological contact with him. *(P4:T9)*

Counsellor P2 summarised it for herself as follows:

If I was going to sum up what is going on for me in that first session. I don't assess whether someone is suitable for short-term work. When I meet with someone it is with a mixture of excitement at the prospect of a new relationship and a sense of challenge - how can I help this person to engage with the process with a degree of urgency so that they can get the maximum benefit from our time together? I want them to feel safe as rapidly as possible and to trust me enough to talk about what hurts straight away. And I want to give them a sense of hope that if they can do that it will be helpful within the time available. *(P2:T22).*

3.3 Counsellors' intra-personal experience.

When asked to expand further regarding the process of assessing suitability for counselling, the words 'gut feeling', a 'feeling' or a 'sensing', were used to describe the process:

. I suppose it's a gut feeling, it's hard to define it I suppose. *(P1:T3)*

It's so vague that I kind of think well I'll just go with my own organismic self I suppose, my own gut feeling with the client. *(P4:T5)*

Sometimes I get the feeling that that isn't going to be quite sufficient for this particular client. *(P3:T1)*

It's a sensing. *(P1:T8)*

Then the counsellors described how they were able to reflect on these feelings and articulate them at a cognitive level:

I may be confused as to why I am not connecting with them ...so I try to work out if it's me... *(P4:T9)*

I suppose first of all it's at a feeling level. I get the feeling this is not comfortable for this person. But then I can justify it cognitively. ...I think my feelings and senses are based on signals that I'm getting from the client although I'm not necessarily processing those in a reasoning way...so I just need to have a think about it really and work out why it is that this person is not suitable for counselling." *(P2:T9)*

3.4 Counsellors' experience.

The experience and training of the counsellors was also reported as being an important factor. Patterns or similarities would be recognised and this helped them to determine whether counselling would be appropriate:

> *I'll discuss it with my supervisor and say: 'in my experience and in my view, this is going to be a much longer situation.* *(P3:T6)*

> *I do know that an entrenched eating disorder is likely to be longer term.* *(P5:T2)*

> *Although we are person-centred, I still think we do have probably a bit more information on human systems...* *(P1:T3)*

3.5 Client autonomy.

Moreover, the counsellors respected the client's autonomy to decide whether counselling would or would not be appropriate:

> *They would stop coming. They would say: 'I don't want to do this' and then go away.* *(P2:T11)*

> *I would leave it up to the client to make the decision as to whether they wanted to come of not.* *(P2:T16)*

> *So it's never what I think really. Which is why it's so much better to trust the client.* *(P5:T9)*

You know at the end of that, I suppose my evaluation will be depending on what the person themselves says. *(P4:T14)*

3.6 Emergent process of assessment.

All the counsellors felt that it was not possible to know or predict whether the work would be long or short term:

Well it's almost inevitably somewhat vague at the beginning of the first session because I don't know the client, the client doesn't know me. *(P3:T2)*

I can't say to them this is what's going to happen and this is how you'll feel because at this point I have absolutely no idea. *(P2:T2)*

At the point of the first session, I think it's quite hard to assess. How do you measure how much we are going to achieve in eight sessions, 'cos I'm not God, I can't predict. *(P4:T13)*

Counsellor P3 stressed the importance of recognising the uniqueness of clients and that it was difficult to adopt general rules:

Recognising that every client is going to be different you have to approach it with that wide range of possibilities. *(P3:T2)*

Assessment for therapy was perceived as more of an emergent, ongoing process rather than something that could be completed in the first session:

I think every session is an assessment really. *(P1:T12)*

It might become apparent during several weeks that actually this person needs something else. *(P2:T5)*

It is ongoing. *(P4:T16)*

3.7 Contracting.

All the counsellors spent time in the first session establishing contracts with their clients, discussing boundaries and completing any necessary administration required by their employing organisation.

I do the contracting and do the HADS score, give them the information on counselling as well that's a back up to what I've said. *(P1:T10)*

I have to fill in a CORE form as well. *(P5:T10)*

It was also an opportunity to explain the nature and purpose of counselling and to check out client's expectations:

I explain a little bit about how counselling works. I say that it's a talking therapy and it's their time for them to talk about whatever it is, without distressing them or disturbing them, that they want to talk about...and I say, how does that sound? Is that what you were expecting? Cos just very occasionally, somebody will be expecting to be given advice. *(P2:T2)*

THEME 4.0

Managing brief therapy

This fourth theme includes six sub categories and describes how counsellors use the resources available to them to help them manage the brief therapy model.

4.1 How clients are referred to the counsellor.

All the counsellors referred to referral pathways as being integral to the way they were able to manage brief therapy. Receiving appropriate referrals was also considered important. Referral processes differed but all went through some degree of screening process whether by the GP, or in the case of self referrals, from a colleague within their team.

> *I do get appropriate referrals from most of the GPs.* *(P5:T5)*

> *They've already had a screening appointment with a CPN or a telephone screening.* *(P2:T3)*

> *What sometimes happens is they've been referred for counselling with the option of referring for psychotherapy if counselling isn't enough but that rarely happens.* *(P2:T9)*

> *We have a preliminary session with every potential client in which the counselling that we offer is explained, things of that sort, the length of time, number of sessions which will be offered.* *(P3:T3)*

4.2 Referral pathways for the counsellor.

Equally important was the opportunity for the counsellor to refer to other mental health professionals. Having a protocol to work to which provided guidelines on who may or may not be appropriate for brief therapy gave the counsellors a framework within which to work :

> *If they were suicidal, I think they would need to be referred to secondary care services.* *(P1:T9)*

> *If I feel that they're in a psychotic sort of place, anything that's not suitable needs to be going to secondary care really.* *(P4:T1)*

> *If there were any exclusion criteria, particularly if the GP ticks several boxes...there's eating disorders, sexual abuse – I'm not supposed to work with sexual abuse either.* *(P5:T6)*

All the counsellors, however, observed that there was a general lack of resources within both the statutory and non-statutory sector and therefore, few opportunities to refer clients on for counselling:

> *There are other places too but they are not ideal. (. . .)There's just not a lot out there.* *(P5:T2)*

> *The majority of cases I usually see within six sessions or less. There are occasions when I do go over that because I feel that to refer them on to a twelve month waiting list elsewhere, (. . .).* *(P1:T1)*

We're very limited as to who we can refer them on to. So it would be have to be someone that either was definite that what they wanted was CBT in which case we could refer them for CBT. *(P2:T5)*

4.3 Accepting all clients for counselling initially.

Not being able to know or predict how many sessions a client would need, the counsellors accepted all clients for counselling initially if the client was willing to come, because they felt much could still be achieved. Counsellor P4 described the process for her:

I've never actually said at the end of a session I can't work with this person because we are not in psychological contact or, you know, eight sessions isn't enough time. ...But I'll give them the benefit of the doubt. *(P4:T14)*

Unless those core conditions can't be met as in there is no psychological contact, but even then I will give the person a chance to see if that changes. *(P4:T14)*

I mean the person might choose not to come back but I don't think I've ever said, definitely I can't work with this person. *(P4:T15)*

I think everyone deserves a chance and you know, that even if you don't reach all these goals that CBT or other goal orientated therapies may set out at the beginning. I think quite often clients that I work with, even if

they've had some glimpse of acceptance or empathy from somebody else and had their story heard, that they've never said before, then that's quite a powerful thing. If that's all that can be offered then that's quite a lot actually. *(P4:T16)*

Referring again to client autonomy (category 3.5) counsellor P2 also spoke of 'having a go' if the client was willing:

As far as I'm concerned I will offer them what I can offer them and if they are willing to have a go. Because sometimes that's what people will say, 'well I'm not sure but I'll give it a go.' *(P2:T16).*

This was echoed by counsellor P5:

If a person is just not hearing what I'm saying or just not engaging, then I'd still give it a go. I'd carry on if they wanted to. *(P5:T12*

4.4 Options to extend therapy.

Although all the counsellors worked to brief therapy contracts of between six and ten sessions, under certain circumstances they were permitted to extend the number of sessions offered. This gave them some flexibility and autonomy with regard to managing the work.

We do have the capacity to extend in certain circumstances, you know. *(P5:T1)*

Counsellor P2 reported that in her agency, counsellors could extend for a further six sessions. Beyond that limit, it would only be sanctioned on the basis of risk:

We can extend beyond the twelve. (. . .)But counsellors have to discuss with me first. They can't just decide on their own and they have to have good reasons and it's usually on the basis of risk. *(P2:T10)*

Sometimes it was reported that clients could be re-referred and brief therapy was then experienced as part of a longer process:

They sometimes have a break and then they come back, you know after a few months. And sometimes I say you can be re-referred and they go straight away and re-refer themselves. *(P5:T4)*

People can be re-referred. Now they can't just keep being re-referred and re-referred because that's like sort of long term therapy by the back door, but it doesn't happen often. (. . .) *(P2:T10)*

Therapy is a bit like climbing a mountain. You don't go straight from the bottom to the top. (. . .) the client could go away and have a go and get used to where they are and put what they've learned into practice. *(P2:T10)*

Sometimes with people who have got lots of layers if you like, you know we can work with a few of those layers. We don't have to go through all twelve of them, or however many layers there might be. *(P4:T14)*

4.5 Importance of the first session as the beginning of the therapeutic relationship.

There may be a requirement for form filling or other organisational requirements but the counsellors did not regard the first session as a stand alone session. The first encounter was the beginning of the therapeutic relationship and valuable work could be achieved.

> *R:So after you've done the CORE then its...?*
> *P:Mmn, yes, in there. But unfortunately there's not a lot of time left.* *(P5:T10)*

> *To me the first time you actually start with people that's when you are beginning to form your relationship* *(P4:T18)*

> *Because it's amazing what comes out in the first session.* *(P1:T1)*

> *I've know people who have come in to the first session and before I can even begin to talk about contracts or anything else they've already started to talk about their problem and they've gone really deep...* *(P3:T11)*

4.6 Counsellors' use of supervision.

Another way the counsellors managed the process of assessment within brief therapy was to use supervision. Counsellor P5 described how she would use supervision when considering the appropriateness of offering brief therapy to a client:

There may be difficulties with some people but take that to supervision and work it out. *(P5:T8)*

Well I feel at the end of the first session I have to say I'm happy to work with you or I'm not sure about working with you and I'm going to need to talk to my supervisor. *(P5:T12)*

Counsellor P3 would refer to the supervisor if further sessions were needed.

I will discuss this with my counselling supervisor ...I say "well I think this particular client is so seriously damaged that it's going to take longer." *(P3:17)*

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS OF FINDINGS

The research outcomes presented a detailed account of the counsellors' experiences, thoughts and perceptions. It is important, however, to acknowledge that the findings can only be tentative at this stage, as the sample size and variance in organisational settings was small. Nevertheless, the research was successful in securing detailed accounts of the counsellors' experiences of assessment for brief therapy and the individual accounts revealed many common themes. I will now discuss these in relation to the literature, explore their significance with relation to the wider professional community and offer recommendations for further research.

My research question aimed to explore person-centred counsellors' experiences of assessment, to understand the meaning it held for them and how it was managed. Wilkins and Gill's (2003) research revealed that using the term 'assessment' was particularly emotive for their participants so they asked them to describe the initial contact. Mindful of this, I also chose to invite my research participants to describe their experiences of the first session with a client.

The participants explained their method of negotiating a contract with boundaries of confidentiality, time of appointments, frequency, number of sessions, together with an explanation of the nature and purpose of counselling. The need to clarify clients' expectations was also expressed, which accords with Parrott (1999) who stresses this as important in the first session.

The administration of assessment tools, such as questionnaires, depended upon the requirements of the employing organisation. Milner and O'Byrne's (2004) research reported counsellors' reluctance to use assessment tools for fear of labelling their clients. The outcomes supported this finding as the counsellors felt they were in a position of power over, or passing judgement on, the client and as such, this was antithetical (Rogers, 1951). There was, however, a resigned acceptance that the

assessment forms were required by their organisation. Although Bozarth (1998) considered the use of assessment tests justifiable when the organisational setting required them, the counsellors in the present study did not report any sense of this being compatible with their person-centred approach and would have preferred to dispense with them altogether.

The research showed support for Wilkins and Gill's (2003) finding regarding the meaning of the word assessment. It had little meaning or relevance for the counsellors and was considered anathema, being synonymous with asking questions, labelling and passing judgement. Diagnosis was categorically rejected as having any place in their practice as this was considered a term which belonged to the clinicians. Issues of power and locus of control were at the heart of their objections and presented a paradigm clash. Rogers (1951) viewed the client as the final diagnostician and the participants clearly felt assessment and diagnosis was a compromise to their person-centredness.

There was no evidence to support Feltham's (1997) view that counsellors needed a wide array of interventions to offer the client in order to be effective in brief therapy. The participants reported the sufficiency of the core conditions and the central role of client as expert. They would 'give it a go' if in doubt and if the client was motivated to engage with the process. Schlien (1989) and Bozarth (2002) discuss the specificity myth at length. Schlien (1989, p. 402) states that in person-centred therapy there is "only one treatment for all cases" and hence diagnosis and assessment for type of intervention, has no place.

Assessment was not considered to be a separate event, but continuous throughout therapy. In this context, the first session was conceptualised as a process of beginning to understand the nature of the client's presenting issues and how the counsellor may be able to help. This reflects, in part, the literature with regard to orienting the counsellor to the presenting problem (Hudson-Allez, 1997; Parrott, 1999). However, it was clear throughout, that the counsellors did not use the conventional language of assessment. Milner and O'Byrne (2004) describe formulation as the central purpose of assessment; the stage between assessment and intervention, where information is processed within a theoretical framework. The participants did not adopt the term

formulation or use words such as goal setting, focal work, assessing emotional strength or level of motivation. Nor did they report any formal assessment structure. This is not surprising, however, as person-centred counsellors would not be expected to align themselves to a model which labelled the client or set agendas for the work. Such approaches shift the locus of evaluation from the client to the counsellor and do not honour the authority of the client.

The counsellors did, however, use Rogers' (1957) term 'psychological contact', (the first of his six conditions for therapy), as being necessary for therapy to begin. This suggests that at some level they were reflecting upon their relationship with the client and forming a judgment about the qualities of that relationship. Information about the client was being processed within a person-centred theoretical framework and a decision made about whether they were able to work with that client. Although the term 'formulation' was not used, this does support Wilkins' (2003) view that there is, unavoidably, some subjective evaluation going on within the counsellor. Whines (1999) suggests it is impossible not to assess because with each new client we generate an internal dialogue about how we perceive them. In this respect, there was a process of internal dialogue although the participants did not recognise this as assessment.

Attempting to understand this internal dialogue further, when the counsellors were asked to explore their process of deciding upon suitability for counselling, words like 'gut feeling' or 'a sensing' were used. This correlates with Milner and O'Byrne's (2004, p. 5) view of assessment as being difficult to define with phrases such as, 'the feeling factor' or 'comfortableness with a client' being used to describe the process. The counsellors tried to symbolise accurately their experiential processes, which began at an intuitive level. By being reflexive, it could then be articulated cognitively. This symbolisation was, however, contextual, and shaped by several relevant, intervening factors, which are discussed below.

Honouring the uniqueness of every client, the counsellors stressed that general rules were not appropriate and could not be applied to predict the course of therapy. Assessment was perceived as emergent and ongoing. On this premise, within existing protocols, the counsellors accepted all clients referred to them and regarded the first

session as the beginning of the therapeutic relationship, rather than something separate.

Sharman and Seber (2002) viewed assessment as a vital stage before counselling could begin and Casemore (2002) suggested it was necessary to identify client goals and the duration of therapy. The outcomes did not support either of these views. On the contrary, the participants were clear that therapy duration could not be predicted, supporting the views of Bohart et al. (1997) and research by Hatchett (2003).

Moreover, goal setting was not part of person-centred theory and practice. The participants reported the focus of therapy changing over time as the relationship of trust developed, which supports Hatcher, Huebner and Zakin's (1986) description of how the trail of the focus changed during the course of therapy.

Schmid's (2003) view is that the person-centred approach is not disorder specific but process specific. This indicates a shift away from focusing on the client, to a focus on the relationship between therapist and client. Predicting the likely course of therapy elevates the counsellor to the position of expert as she attempts to label and categorise and would not be compatible with the person-centred approach.

This was empowering for the participants, as they were free to respect the client's autonomy to decide if therapy would or would not be appropriate. This is compatible with Rogers' (1951) view of psychological diagnosis as a process that is located in the client not the therapist and counters Casemore's (2002) assertion that it is unethical to offer therapy without a rigorous assessment.

This may be important for managers to consider in service design, especially those services employing a triage system, which the government's new IAPT service will be using. If clients are assessed separately by a triage team and allocated to therapists, the question remains as to how effective or accurate such assessments and predictions of duration and type of therapy will be.

Renk, Dinger and Bjugstad (2000) proposed that client psychopathology was not as important as counsellor experience in predicting therapy duration. The counsellors in

the present study were experienced practitioners and reported how they were able to draw upon their experience and training when deciding whether to work with a client. The value of supervision as a place for further guidance and support was also mentioned. Exactly what cognitive schema was being used to assimilate and differentiate information in this process could provide the basis for further research. However, there are implications for training and supervision and it is relevant to ask if counselling trainees are given sufficient opportunities to explore the challenges of working in brief and/or time limited settings. Opportunities to explore their perceptions and feelings towards the brief therapy model could be valuable in preparing person-centred counsellors for this work. Service managers may also need to consider training needs and support for counsellors working in brief therapy.

The findings suggest further support for Mearns and Thorne (1999) and Wakefield (2005) who advocate flexibility with regard to the number of sessions offered rather than a strict limit. Time limits take away power from both counsellor and client, presenting obstacles to person-centred work (Mearns & Thorne, 1999). Although the counsellors did not have open-ended contracts, having the option to extend the number of sessions helped them to work with greater flexibility and autonomy according to client need. Further flexibility was achieved via re-referral whereby clients might take a break from counselling and be re-referred later.

It could be argued this mirrors the process of longer term counselling. Tudor's (2008, p. 15) reference to 'moments of movement' articulates the view that change can and does happen in an instant. It is not the time frame that is important, because such moments may happen after two or twenty-two sessions, but the quality of the change that is significant. Paul Wilkins (personal communication, June 16, 2008) adopts a similar view suggesting that all therapy may be brief therapy. He too refers to moments of significant movement and suggests that in between there are periods of maintenance. In brief therapy, people may return following a break and explore issues further, which may echo what happens in longer-term therapy. There are implications here for service design and for considering whether time-limited therapy is more effective than brief therapy.

It was usual for the counsellors to work to organisational guidelines as to who may or may not be suitable for brief therapy. There was also the option of referral to other services, which provided the counsellors with a framework for accepting and referring clients. The referrers, whether a GP or someone screening initial inquiries, were integral to this process and there was broad agreement among the counsellors interviewed that most of the time referrals were appropriate.

The referral pathways were felt to be helpful for those times when it was clear further intervention might be needed, based on an assessment of risk or when the presenting issue was clearly outside the counsellor's area of competence. This finding would appear to lend support to the literature listing exclusion criteria for brief therapy (Department of Health, 2001; Dryden & Feltham, 1992). However, the counsellors also reported that alternative services in both the statutory and non-statutory sector were under resourced, limited or not available.

Tudor (2008), however, urges therapists to question the assumptions for using exclusion criteria. He states these often arise from a medical model of diagnosis and treatment, a view that is antipathetic to person-centre values. Moreover, he argues that faced with limited resources, the organisation demands assessment in order to fit the client with the treatment on offer. As such, the exclusion criteria become service rather than client centred.

The outcomes revealed the counsellors did feel frustrated with the imposition of exclusion criteria, especially where alternative services were lacking or where the counsellor felt the client's presenting issue was within her area of competence.

> *I find it very difficult because really I am willing to work with this person.* *(P5:T3).*

> *the words sexual abuse don't automatically mean that it's going to be long term work.* *(P5:T6).*

Some of the counsellors felt the criteria were too prescriptive, lending support to Chiesa, Fonagy and Bateman's (2007) research, which indicated persistence of

symptoms rather than the presenting issue itself be used as an indicator of the type of therapy offered. The government's IAPT service will adopt a stepped care approach to intervention based on an assessment of individual needs and severity of problem and offering the least intense form of therapy first (NICE, 2004). Such a model may allow for a more client centred way of working, although the evidence for this approach to allocating clients to therapy is not strong. Equally, the exact form of stepped care needed to maximise benefit to clients is unclear (Turpin, Richards, Hope & Duffy, 2008). The ability to predict those clients who would benefit from lower intensity treatments remains questionable and there is plenty of scope for further research here.

A client's readiness for counselling was reported by the participants as a key determinant for effective brief therapy. This finding is consistent with Wilkins and Gill's (2003) theory regarding the relevance of Rogers' (1961) seven stages of process for providing a theoretical framework and guide for the counsellor when meeting a client for the first time and throughout the process of therapy. The participants were assessing client's motivation and commitment to engage with the process of change. This was not a formal, structured process, but interpretive and based on cues and impressions from the client. Wilkins and Gill (2003, p. 185) state: "person-centred therapy has not only a guide to when and for whom therapy is appropriate, but an indication that different 'ways of being' by the therapist in the encounter suit different stages." They add that at different stages of process, there are qualitative differences of intent required of the therapist and all of this requires a judgment and appropriate action by the therapist. This, they state, is assessment.

A common thread running throughout the counsellors' narratives was their positive view of brief therapy. They felt it was important to convey this to clients, to instil hope that change could happen. This confirms Feltham's (1997) assertion that an attitude of openness and commitment to the process is important not only for the counsellor to feel affirmed within her work, but also for the client who may feel more motivated to progress with the work.

This outcome appears to counter the criticism of those who doubt the sufficiency of the core conditions in brief therapy. With reference to time-limited therapy, Hudson-Allez (1997, p. 35) states:

> Person-centred counselling, in truly Rogerian style, is totally non-directive. Clients may meander for a long while before reaching their desired goals. To reduce the time, therefore, it is necessary to introduce some street signs to show the client where he is going.

Casemore (2002) also doubts whether person-centred counselling can be offered within a brief setting because, he argues, it is difficult to establish psychological contact within a short time frame. However, not only did the participants report being able to establish psychological contact but they also reported the sufficiency of the core conditions for therapeutic change.

I believe this finding is particularly relevant for the person-centred practitioner as it affirms the effectiveness of her approach within a brief therapy model and in turn will have a significant influence on any assessment process regarding suitability for this work. Tudor (2008, p. 16) expresses the view that 'the challenge of brief therapy is simply to be the best we can be in a shorter time; no more, no less.' This view helps the counsellor to remain aligned to her person-centred values and attitudes without capitulation to an 'instrumental approach' (O'Hara, 1999, as cited by Tudor, 2008) where techniques are used in order to bring about change.

Rogers (1942), states it is the therapist's task to help the client explore his feelings with regard to time. Trainers and supervisors may also need to help counsellors to do likewise, especially those working to time limits, to examine whether they can trust the process of actualisation as a motivational force for growth which occurs irrespective of time limits.

An additional theme emerging from the data was the influence of the brief therapy model on the client and counsellor's interpersonal processes. This is relevant as an intervening factor and leads to a further understanding of the counsellors' positive attitude towards brief therapy. Strasser and Strasser (1997) observed that restrictions

to time affect the process of therapy for both client and counsellor. The participants in the present study reported how time limits motivated their clients to get on with the work and the counsellors noticed how they, too, felt they had to work hard from the beginning. They reported offering the core conditions intensely and immediately so the therapeutic relationship could be established as quickly as possible, echoing Thorne's (1994) account of time-limited work. Hoyt (1990) stresses the importance of seizing the moment and not wasting time and the counsellors described how their work became more focused or their interventions more challenging. However, this was expressed as a quality they noticed had developed over time, rather than an instrumentalist approach they had adopted to hasten the process. This also accords with Rogers' (1942, p. 101) view of time restrictions that, 'the time limit sets up an arbitrary human limit, to which the client must make adjustment." There is no requirement for the therapist to hasten the process in any way.

This finding is of significance for the person-centred counsellor as it awakens the directivity debate and how practitioners interpret their approach. Keys (2003) discusses this in her edited book presenting accounts of how person-centred therapists enact their approach and states that sometimes nondirective is misinterpreted as being passive and therefore to be active is considered directive. Grant (2002), in distinguishing between principled and instrumental non-directiveness focuses on the issue of intent and attitude of the therapist. He regards instrumental non-directiveness as a technique whereas to be non-directive in a principled way is to adopt a moral position of respect for the autonomy of the client. Keys (2003) states how the fear of being judged can stifle idiosyncrasy as it leads to doubts and raises the spectre of the 'thought police' (p. 12). Wakefield and Wakefield's (2005) criticism of Gibbard's (2004) article describing person-centred counselling in a time-limited setting and Gibbard's (2005) response to this, illustrates this well.

A final observation concerns the use of the CBT model by some of the participants who had received some training in CBT skills and techniques. They used this training to inform their work when appropriate. Such occasions arose if the client asked for CBT and if it could be offered in a way that honoured the person-centred attitude.

As already discussed above, the use of techniques is contentious as it questions the sufficiency of the core conditions (Wilkins, 2003). Whether using techniques can ever be considered compatible with person-centred theory remains an area of discussion and considerable dissent among its practitioners. The counsellors in the present study were clear that the use of CBT techniques arose out of their work with their clients and was, therefore, consonant with their person-centred attitude according to Merry's (1999) definition.

The findings from this research lead me to suggest that the brief therapy model does not pre-suppose assessment as a vital stage before therapy can begin. The counsellors were positive about their ability to work within brief therapy without compromise to their person-centred attitude and this positive attitude instilled hope and confidence that much could be achieved. Assessment for suitability for counselling was a continuous process embedded within the relational aspects of the activity rather than something separate, formalised or structured.

CHAPTER SIX

CONCLUSIONS

This research arose from a curiosity on my part, with regard to how person-centred counsellors manage the assessment session for brief therapy. Being informed by Wilkins and Gill's (2003) research, I wanted to understand the process within a brief therapy context and to be able to reflect upon the implications for practice. My purpose was not to reveal universal truths but to explore the issue of assessment with fellow counsellors in the hope of adding to an understanding of the process.

It became clear that the process of assessment was not a separate event that could be isolated and analysed critically but was contextual and continuous throughout therapy. Hence, for the research participants, a discussion about the first session became intrinsically linked with a wider discussion about brief therapy itself.

I started with an assumption that all counsellors would be explicitly assessing for suitability and duration of brief therapy in the first session. However, the process of assessment was conceptualised as an ongoing, emergent process and counsellors' perceptions during the first session were contingent upon their underlying positive attitude and expectations regarding the process of brief therapy itself. This positive view was reinforced by their years of experience of working in brief therapy, coupled with the ability to integrate a degree of flexibility with regard to the number of sessions offered. The counsellors offered a therapeutic relationship trusting the sufficiency of the core conditions and in the client's ability to adjust to the time frame and to use if for his benefit (Bryant-Jefferies, 2003). This was both freeing and facilitative for the counsellor and decisions about duration and whether brief therapy would be suitable were not considered necessary.

Milner and O'Byrne's (2003, p.140) study of assessment across the main theoretical approaches found that all the counsellors in the study, regardless of theoretical orientation, found it difficult to explain *how* they made assessments suggesting that

there is no right way. The fundamental question being asked in the initial stages of therapy is, can.we work together? The research findings suggest this is how person-centred counsellors also conceptualise assessment but that they do not align themselves to the language and terminology generally used by other practitioners.

Wilkins and Gill's (2003) research revealed a deeper understanding of the processes involved in assessment for therapy. The outcomes from this present study would also appear to support their findings with respect to assessment for brief therapy. Person-centred counsellors do have a theory of assessment but this is based on a judgment about aspects of the relationship rather than something that is done *to* clients. This has important implications for person-centred counsellors within the wider therapeutic community. The future of Person-centred therapy in the UK is currently not strong compared to Europe and is thought by many outside of the approach to be naïve, simplistic and ineffective (Sanders, 2008). With the increasing dominance of brief and other forms of therapy, that aspire to the medical model of diagnosis and treatment, it becomes incumbent upon the person-centred counsellor to defend her position with regard to assessment and that she has the language and theory to do so. As Wilkins (2003, p. 48) points out the criteria of therapist intent is fundamental to the person-centred approach and this forms the basis of assessment.

The counsellor's attitude of non-directivity underpins the person-centred philosophy and as discussed, this attitude has been challenged by some in relation to brief therapy. The counsellors in the present study did not feel their person-centredness was being compromised. In selecting counsellors who called themselves person-centred, I can only assume this reflects, to a small degree, the views of those working within the person-centred approach.

Although the sample for this research was small, it does present a snapshot of the perceptions of person-centred counsellors who are currently juggling the demands of brief work within a person-centred paradigm. It offers an informed contribution to those who question whether the person-centred approach is appropriate for brief therapy and more specifically, how they assess for suitability.

Recommendations for Further Research.

The results of this study suggest a number of directions for further inquiry.

1. The sample was limited to five and the majority of the participants worked in healthcare settings. Therefore, results could be criticised as reflecting the experiences of those working in NHS settings. Further research using a larger sample and from different organisational settings may generate different categories. However, the variance in organisational setting was limited owing to a lack of respondents from quarters outside the NHS and this may reflect the dominance of brief therapy within healthcare settings. It is also noted that all of Wilkins and Gill's (2003) research participants worked in healthcare settings.

2. The limits to time and resources meant that as sole researcher, even with the most rigorous monitoring of my biases and assumptions, researcher bias was inevitable. Having a co-researcher would go some way towards reducing such bias.

3. It would be useful to build on Hatchett's (2003) research to examine whether assessment of severity of presenting issue and likely duration of counselling is an accurate indicator for treatment option. Moreover Wilkins' view (personal communication, June 16, 2008) that all therapy may be brief therapy invites further research to examine whether clients do better in longer term rather than periods of brief therapy.

4. Marzanos (2006) research indicating that depressed clients were more likely to be helped when offered between nine and sixteen sessions suggests flexibility with regard to the number of sessions offered may be more appropriate to the needs of clients. The findings of this present study suggest that further research may be helpful to examine whether a self-regulating service is more appropriate and cost effective both in the long and short term. It would also be useful to repeat the present study using counsellors who work within a time-limited model and to consider whether the influence of a strict time constraint influences the assessment process in any way.

5. I was unable to find references in the literature that explored the impact of organisational restrictions (with regard to who is appropriate for brief therapy) during the assessment stage with a client. Further research in this area may be useful for both counsellors and service managers so these tensions could be more fully understood.

6. The concern with purity of approach has been highlighted with regard to the counsellors reporting how they worked more intensely from the beginning. This aspect of brief therapy invites further investigation to explore and compare moments of interpersonal exchange between counsellor and client within brief and longer-term therapy. It would be of interest to explore whether this more 'intense' focusing requires something different of the counsellor and whether as Feltham (1997) suggests, there are new skills to be learned. Furthermore, the question remains as to whether this presents a compromise to genuineness as Toal (2001) suggests or whether the intensity of relating is an unconscious response to time limits on the part of the counsellor.

7. The counsellors' use of CBT, or other techniques adopted from other theoretical approaches, is of interest as it may indicate a trend among person-centred counsellors to adopt techniques from other orientations. The reasons for this can only be speculated upon at this point but this does invite further research into how the personal model of the person-centred counsellor evolves post-training. Moreover, the heavy focus of CBT within the IAPT programme may impact upon a counsellor's practice and those working in healthcare settings may, in future, feel increasing pressure to integrate this toolkit into their approach.

8. Using a single methodology yielded one version of the social world. Repeating the research using different methodologies, such as open-ended questionnaires, based on the initial findings of the present study, may provide additional data to increase the trustworthiness of the current data.

9. The research used experienced person-centred practitioners. It would be interesting to explore how experience might influence counsellor's concept of

assessment and attitudes could be compared to those who were newly qualified. Moreover, it might be possible to develop an assessment protocol that is more fully attuned to person-centred practice.

This research was about five counsellors' experiences in a brief therapy setting. Their accounts made this study possible. I have endeavoured to be faithful to their stories and am indebted to them for their openness, honesty and for so freely giving of their time. This is their contribution to a greater understanding of the person-centred approach.

EPILOGUE

This research has been a journey of many parts. It arose from my uncertainties, musings and passion for my chosen theoretical approach within a world that appeared to align itself increasingly towards those models that could offer a 'quick fix' or demonstrate a strong evidence base, so important in these days of accountability and cost-effectiveness. I questioned my determination to continue to work within the person-centred approach, yet fearing that it might become subsumed by the behemoth of an organisation that adopted the medical paradigm. My colleagues from other theoretical backgrounds spoke the language of the medical world; at times, I felt inadequate. I wondered if I needed to adapt or change my approach. Was I perhaps letting my clients and myself down by not doing so?

I began the M.A. course with no clear agenda other than a thirst to stretch and challenge myself both personally and professionally. However, I was not looking forward to the research element of the course, as I knew it would place huge demands upon my time and energies and having completed a dissertation only a few years earlier, I was in no hurry to start another.

I did not know what to research and spent many weeks pondering my research question. It was a reading of Feltham's (1997) book on time-limited counselling that prompted the direction and his discussion upon the need for assessment. Even then, I was unsure about its relevance and where the research would lead.

The process of research itself has been demanding of time and resources and many times, I pushed myself to continue. However, I have learned to enjoy the process and relished collecting and analysing the data, searching and reading through the literature, bringing the whole together into a shape and form that assumed meaning and relevance.

I have also learned to trust myself more as a counsellor and feel reaffirmed as a person-centred practitioner. Equally, I have learned to trust the client's process more and to trust the process of brief therapy itself.

It has been an invaluable experience to meet other practitioners and to hear their stories and I am indebted to them. I believe my research has gone some way towards endorsing the effectiveness and credibility of the person-centred approach.

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APPENDIX 1A

WEBSITES AND DATABASES USED FOR LITERATURE SEARCH.

Person-centred websites.

- British Association for the Person-Centred Approach (BAPCA) (www.bapca.org.uk).
- World Association for Person-Centred and Experiential Psychotherapy and Counselling (WAPCEPC) (www.pce-world.org).
- The Person-Centred Website maintained by Peter Schmid (www.pfs-online.at).
- The Association for the Development of the Person-Centered Approach (ADPCA) (www.adpca.org) .

Other websites

- British Association for Counselling and Psychotherapy (www.bacp.co.uk).

Bibliographic surveys of person-centred literature.

- Allan Turner's bibliography available from the BAPCA website.
- Paul Wilkins and Germain Lietaer's bibliographical survey of English publications since 2000 available from the WAPCEPC website.
- Peter Schmid's bibliography of English publications available from his website (www.pfs-online.at).

Online electronic databases used (1998 – 2008)

- **AMED**
- **BNI**
- **CINAHL**
- **EMBASE**
- **HEALTH BUSINESS ELITE**
- **HMIC**
- **MEDLINE**
- **PsycINFO**
- **BMJ (2000 – present)**

APPENDIX 1B

Healthcare Databases *Advanced Search*

Search history

SAVE SELECTED ROWS SAVE ALL

No.	Database	Search term	Hits
1	MEDLINE, MEDLINE	exp BEHAVIOR AND BEHAVIOR MECHANISMS/ OR exp PSYCHOLOGICAL PHENOMENA AND PROCESSES/ OR exp MENTAL DISORDERS/ OR exp BEHAVIORAL DISCIPLINES AND ACTIVITIES/ [Limit to: Publication Year 1998-2008]	1045417
2	MEDLINE	suit*8.ti,ab [Limit to: Publication Year 1998-2008]	100821
3	MEDLINE	assess*4.ti,ab [Limit to: Publication Year 1998-2008]	702546
4	MEDLINE	"person cent*4".ti,ab [Limit to: Publication Year 1998-2008]	403
5	MEDLINE, MEDLINE	1 AND 2 [Limit to: Publication Year 1998-2008]	10000
6	MEDLINE	1 AND 3 [Limit to: Publication Year 1998-2008]	169302
7	MEDLINE	"brief psychotherapy".ti,ab [Limit to: Publication Year 1998-2008]	59
8	MEDLINE	"brief therapy".ti,ab [Limit to: Publication Year 1998-2008]	66
9	MEDLINE	"brief counsel*4".ti,ab [Limit to: Publication Year 1998-2008]	142
10	MEDLINE	(brief AND counsel*4).ti,ab [Limit to: Publication Year 1998-2008]	868
11	MEDLINE	(brief AND therapy).ti,ab [Limit to: Publication Year 1998-2008]	3442
12	MEDLINE	(brief AND psychotherapy).ti,ab [Limit to: Publication Year 1998-2008]	352
13	MEDLINE	"short term counsel*4".ti,ab [Limit to: Publication Year 1998-2008]	12
14	MEDLINE	"short term psychotherapy".ti,ab [Limit to: Publication Year 1998-2008]	39
15	MEDLINE	"time limited counsel*4".ti,ab [Limit to: Publication Year 1998-2008]	0
16	MEDLINE	"time limited therapy".ti,ab [Limit to: Publication Year 1998-2008]	7
17	MEDLINE	("time limited" AND therapy).ti,ab [Limit to: Publication Year 1998-2008]	123

No.	Database	Search term	Hits
18	MEDLINE	"Rogerian therapy".ti,ab [Limit to: Publication Year 1998-2008]	2
19	MEDLINE	"Rogerian counsel*4".ti,ab [Limit to: Publication Year 1998-2008]	0
20	MEDLINE	1 AND 4 [Limit to: Publication Year 1998-2008]	306
21	MEDLINE	2 AND 20 [Limit to: Publication Year 1998-2008]	6
22	MEDLINE	3 AND 20 [Limit to: Publication Year 1998-2008]	64
23	MEDLINE	("person cent*4" AND counsel*4).ti,ab [Limit to: Publication Year 1998-2008]	8
24	MEDLINE	("person cent*4" AND therapy).ti,ab [Limit to: Publication Year 1998-2008]	28
25	MEDLINE	1 AND 2 AND 3 AND 4 AND 9 [Limit to: Publication Year 1998-2008]	0
26	MEDLINE	3 AND 7 [Limit to: Publication Year 1998-2008]	11
27	MEDLINE	3 AND 10 [Limit to: Publication Year 1998-2008]	336
28	MEDLINE	2 AND 10 [Limit to: Publication Year 1998-2008]	18
29	MEDLINE	1 AND 4 AND 9 [Limit to: Publication Year 1998-2008]	0
30	MEDLINE	1 AND 4 AND 8 [Limit to: Publication Year 1998-2008]	0
31	MEDLINE	3 AND 12 [Limit to: Publication Year 1998-2008]	101
32	MEDLINE	2 AND 12 [Limit to: Publication Year 1998-2008]	9

Combine with: AND OR

COMBINE SELECTED SEARCHES DELETE SELECTED SEARCHES REMOVE DUPLICATES

View your clipboard (0)

Search

You are currently searching: **MEDLINE**. Search using different databases

APPENDIX 1C

Healthcare Databases *Advanced Search*

Search history

SAVE SELECTED ROWS SAVE ALL

No.	Database	Search term	Hits
1	PsycINFO	BRIEF PSYCHOTHERAPY/	4677
2	PsycINFO	assess*4.ti,ab	317180
3	PsycINFO	1 AND 2	629
4	PsycINFO	suita*4.ti,ab	11565
5	PsycINFO	suita*5.ti,ab	11566
6	PsycINFO	1 AND 5	44
7	PsycINFO	"person cent*4".ti,ab	1528
8	PsycINFO	1 AND 7	7
9	PsycINFO	humanistic.ti,ab	4467
10	PsycINFO	1 AND 9	13
11	PsycINFO	suita*6.ti,ab	13724
12	PsycINFO	1 AND 11	84
13	PsycINFO	counsel*4.ti,ab	68775
14	PsycINFO	1 AND 13	469
15	PsycINFO	14 [Limit to: Publication Year 2003-2008]	79

Combine with: AND OR

COMBINE SELECTED SEARCHES DELETE SELECTED SEARCHES REMOVE DUPLICATES

View your clipboard (0)

Search

You are currently searching: **PsycINFO**. Search using different databases

APPENDIX 1D

Healthcare Databases *Advanced Search*

Search history

SAVE SELECTED ROWS | SAVE ALL

No.	Database	Search term	Hits
1	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	(assess*4 OR suit*8, AND "brief counsel*4" AND ,).af [Limit to: Publication Year 1998-2008]	0
2	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	(brief AND psychotherapy).af [Limit to: Publication Year 1998-2008]	26688
3	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	(brief AND counsel*4).af [Limit to: Publication Year 1998-2008]	22824
4	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	suit*8.af [Limit to: Publication Year 1998-2008]	275120
5	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	(suit*8 AND "brief counsel*4").af [Limit to: Publication Year 1998-2008]	275
6	AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE	(suit*8 AND "brief psychotherapy").af [Limit to: Publication Year 1998-2008]	462

Combine with: AND OR

COMBINE SELECTED SEARCHES | DELETE SELECTED SEARCHES | REMOVE DUPLICATES

View your clipboard (0)

Search

You are currently searching: **AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE.** Search using different databases

APPENDIX 2A

Advertisement placed on the notice boards of local training institutions

PERSON-CENTRED RESEARCH

Would you be interested in taking part?

As part of my M.A. degree in counselling studies at the University of Chester, I am undertaking some research into the experiences of Person-Centred counsellors who assess for brief therapy.

My working title is:

Person-centred counsellors assessment for brief therapy. A small scale qualitative study of the experiences of person-centred counsellors working in a brief therapy setting.

I am looking for person-centred counsellors who work within a brief therapy setting who would be willing to complete a short questionnaire and who would be willing to participate in an interview at a later stage.

If you are interested, I should be grateful if you could please contact me by letter, telephone or e-mail as soon as possible.

Tel:

E mail:

Address:

THANK YOU

APPENDIX 2B

Advertisement sent to *Person Centred Quarterly*

RESEARCH INTO PERSON-CENTRED COUNSELLORS' ASSESSMENT FOR BRIEF THERAPY

I am researching person-centred counsellors' thoughts and experiences of 'assessment' for brief therapy as part of my MA studies at the University of Chester. I am seeking to contact person-centred counsellors living or working in North West England or north Midlands who work to brief therapy contracts and who would be willing to complete a short questionnaire followed by an interview.

If you offer brief therapy and would be willing to take part in this research I would love to hear from you.

Contact: Jane Knight. *(Telephone and email given).*

Advertisements sent to *Therapy today.*

Person-centred research; assessment for brief therapy. Person-centred counsellors working to brief contracts needed for confidential questionnaire and interview. *Telephone and email given.*

Cheshire/Staffordshire person-centred practitioners sought who work to short term contracts for confidential questionnaire and interview. *Telephone and email given.*

APPENDIX 2C

MA IN COUNSELLING STUDIES
UNIVERSITY OF CHESTER

RESEARCH QUESTIONNAIRE

Thank you for agreeing to complete the attached questionnaire, which should take you approximately ten to fifteen minutes.

I am undertaking some research as part of my M.A. in Counselling Studies at the University of Chester and am interested in exploring the experiences of person-centred counsellors who are required to assess for brief therapy. My working title is:

Person-centred counsellor's assessment for brief therapy. A small scale qualitative study of the experiences of person-centred counsellors working in a brief therapy setting.

The purpose of this questionnaire is to find person-centred counsellors, from a variety of organisational settings, who offer brief therapy contracts and who would be willing to participate in an interview to explore the process of assessment from a person-centred perspective.

All information provided by you will be treated confidentially.

Thank you for your support.

Jane Knight
Address

Email:

Tel:

APPENDIX 2C CTD.

MA IN COUNSELLING STUDIES, UNIVERSITY OF CHESTER
RESEARCH QUESTIONNAIRE

1. In which organisational setting(s) do you work? Please tick any that apply.

   - NHS
   - Education
   - Private sector
   - Voluntary sector
   - Other (please specify below)

2. Do you hold a Diploma in Counselling? Y/N

   If not, please state your professional counselling qualifications.

3. What was the core theoretical model of your Diploma (or other) training course?

4. How many years have you been working as a counsellor since completing your counselling diploma (or other, if not diploma)?

5. Is the theoretical approach for your practice mainly person-centred? Y/N

6. With regard to your person-centred practice, where would you place yourself on a continuum from 1 to 7, where 1 is purist person-centred and 7 is integrative? Please indicate below by circling the number which you feel most accurately describes your position and explain briefly why you have chosen this position.

   PURIST 1 2 3 4 5 6 7 INTEGRATIVE

APPENDIX 2C CTD.

RESEARCH QUESTIONNAIRE CTD

7. Are you required to work to brief therapy contracts? **Y/N**
(Brief therapy is identified here as therapy which is offered for a limited number of sessions, typically 6 to 8. It is distinguished from therapy that just happens to be short term.)

8. If so, please state how many sessions you are able to offer.

9. Do you offer an initial session in which you decide whether brief therapy is appropriate? **Y/N**
If not, how is the decision to offer brief therapy made?

10. Are you currently in regular supervision for your practice? **Y/N**

11. Do you operate by a Code of Ethics for your practice? **Y/N**
Please state which one.

12. Would you be willing to participate in an individual interview, of approximately one hour, to explore your experiences during the initial session? The contents of the interview will be confidential and bounded by the *Ethical Guidelines for researching counselling and psychotherapy* (Bond, 2004). If so, please give contact details overleaf.

Many thanks for completing this form. Your support is very much appreciated.

Jane Knight

References
Bond, T. (2004). *Ethical Guidelines for researching counselling and psychotherapy.* . Rugby:BACP

I am willing to be contacted with a view to taking part in an interview as part of your research.

Name and address:

Contact telephone number.
Email address.

APPENDIX 2D

Letter to those not selected for the sample.

Dear

Re: MA research – completed questionnaire

Thank you for completing and returning the questionnaire for my research into person–centred counsellor's assessment for brief therapy.

I will not need to interview you at this stage but the information you have given me is useful for my research and I may contact you again later with a view to an interview. Your completed questionnaire will be held, confidentially, by me and destroyed when my research is complete.

Thank you again for your time and support.

Kind regards

Yours sincerely

Jane Knight

APPENDIX 2E

Researcher's interview guide.

I am interested in the process of beginning and contracting to work with a client who is being offered brief therapy.

You are invited to explore and explain your thoughts and experiences of the first session, what decisions you may make and how the use of person-centred theory influences the process of beginning and contracting to work with a client for brief therapy.

Would you like to start with whatever stands out for you about the initial session with a client?

Prompts for researcher

- How are clients referred?
- Who decides brief therapy?
- How does the first session differ from other sessions? Is it information gathering or a therapeutic encounter? –
- Are clients referred to other colleagues or agencies by the counsellor? How does the counsellor decide?
- Meaning of the word assessment to the counsellor?
- Are there any ways in which working to a brief therapy model influences the process during the first session?
- How does the counsellor's use of person–centred theory influence the process of beginning and contracting with a client?
- Are there other influences?

APPENDIX 2F

UNIVERSITY OF CHESTER

M.A. in Counselling Studies Research

Consent Form
Written questionnaire

I .....hereby give consent for the details of a written questionnaire between me and Jane Knight to be used in preparation and as part of a research dissertation for the M.A. in Counselling Studies at the University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the questionnaire may be seen by Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these people are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy.

I understand that I can withdraw the questionnaire before publication of the dissertation. Upon completion of the research, the questionnaire will be destroyed.

Excerpts from the questionnaire may be included in the dissertation. Copies of the dissertation will be held in the University of Chester Library and the Department of Social and Communication Studies Resource Room.

Without my further consent some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Finally I believe I have been given sufficient information about the nature of this research including any possible risks, to give my informed consent to participate.

Signed (participant).....

Date.....

Signed (researcher).....

Date.....

APPENDIX 2G

Pre –interview letter to participants.

Address

Dear

Person-centred counsellors' assessment for brief therapy. A small scale qualitative study of the experiences of person-centred counsellors working in a brief therapy setting.

Thank you for agreeing to take part in this interview, which will form the basis for my M.A. research.

The purpose of the interview is to explore your thoughts and experiences about the initial session with a client, prior to brief therapy. The attached guide provides an outline.

In order to analyse the information for my research, it will be necessary for me to audio record the full interview on a digital recorder and to complete a full transcript of the interview. I will hold the recording in a safe place where only I have access to it and it will be coded with a number, not your name, so only I will know your identity.

I will ensure your name and identity remain completely confidential and not associated with the written transcript. The information from the transcript will be used solely for the purposes of the research. You will be given the option of reviewing the written transcript and you have the right to ask for portions of the data to be removed if you wish. Upon completion of the research, I will erase the audio recording.

My research is supervised by Dr Rita Mintz at the University of Chester.

I have enclosed two consent forms for you to complete; one is for your own records, the other is for myself. If you are happy with the arrangements for the interview, please sign both copies of the consent form. I will collect my copy when we meet for the interview. Please contact me by telephone or email if you have any questions concerning the interview.

Thank you very much for agreeing to take part in this research. I look forward to meeting you.

Kind regards

Jane Knight

APPENDIX 2G CTD

INTERVIEW GUIDE FOR PARTICIPANTS

I am interested in the process of beginning and contracting with a client who is being offered brief therapy.

You are invited to explore and explain your thoughts and experiences of the first session, what decisions you may make and how the use of person-centred theory influences the process of beginning and contracting with a client for brief therapy.

The interview will be unstructured allowing you to tell your unique story.

APPENDIX 3A

THE PROCESS OF DATA ANALYSIS

1. I typed each interview onto different coloured paper, identifying each transcript by the participant code; P1 to P5 and the interview transcript, T1 to T5. As I transcribed the data, I was already beginning the immersion phase and various themes began to emerge although these were only vague ideas and concepts at this stage. The transcripts were verbatim accounts although I omitted most of the 'mmms', 'ers', short pauses, silences, laughter and body language as these were not considered relevant for the purposes of this study.

2. I engaged in 'purposive reading' of each transcript (Richards, 2005, p. 67), questioning the record, commenting on it and beginning to form concepts. Initially I skim read each transcript but then returned to each one and read more thoroughly. At the front of each transcript, I attached a blank sheet on which I kept a journal of the emerging themes and patterns (see Appendix 3B). This was the beginning of an identification of concepts from the data. I adopted Lyn Richards' (2005) technique of asking myself questions such as: Why?, Why interesting? Why will the research benefit from that concept? I played with and thought about the ideas and began to write conceptually and analytically. Not just writing what the original record said. I began to feel surprised by what emerged.

3. I developed a **'discovery sheet'** following Maykut & Morehouse's (1994, p. 133) method. On a large piece of paper I wrote the focus of inquiry and pinned it on the wall. On a second, larger piece I wrote the word 'DISCOVERY' and recorded recurring words, phrases and concepts, linking them together into patterns and themes. This was not a linear list but a spread of ideas. This helped me to make an initial sift of the mass of data so that I could discern some of the patterns that were emerging. The data began to take shape; a distillation from the mass of words.

4. Explaining this discovery sheet to my supervisor helped me to conceptualise the data further into major themes. This was a further distillation of ideas. Each time I re-read the data and considered the patterns and themes, the focus became clearer.

5. **Unitizing the data.**
   This involved identifying 'units of meaning' (Maykut & Morehouse, 1994, p. 128). Referring to my journal notes and to the discovery sheet, I re-read the transcripts, line by line, underlining units of meaning and in the left hand margin indicating with a word or phrase the essence of the unit's meaning. Then, I cut the units of meaning from each transcript, glued each one to a separate 5" x 8" index card and annotated the card with the word or phrase chosen to represent the essence of the meaning. I also indicated the source of the unit of meaning by means of participant number and page number.

6. **The 'constant comparative' method of analysis (Maykut & Morehouse, 1994, p. 134).**
For this process, I needed a large physical space in which to work and to spread large sheets of paper. I pinned the discovery sheet and focus of inquiry on the wall. This also provided a visual record of the data in which I could immerse myself further.

Reviewing the discovery sheet and my notes/journal, I selected one prominent theme or idea, wrote this onto an index card and attached this to a large sheet of paper. This was my first provisional category. I read the unitized data cards, to identify any that appeared to fit this provisional category and attached each one to the sheet of paper. I used the 'look/feel alike' criteria as described by Maykut & Morehouse, (1994, p. 137). Each time I identified a data card that appeared to belong to the provisional category, I compared it to the first. If it did not fit, I examined the discovery sheet, selected a new category, wrote this on an index card which I taped to a new sheet of paper and attached the data card.

7. In this systematic way, categories of meaning were inductively derived from the data. If some data cards seemed to fit more than one category, I copied them and included them in both. I collected a set of miscellaneous cards. These were mostly parts of the transcript where I, the researcher, had asked questions. Others were occasional anecdotes from the participant, used to break up a statement. Before completing the analysis, I revisited these for possible inclusion.

   Each category name was coded using a capital letter or letters which in some way related to the category and provided a recognizable cue, e.g. 'Trust' (T), 'Client's readiness for counselling' (RC). Each index card was similarly coded.

8. **Creating propositional statements.**
When I had accumulated several data cards against each provisional category, I listed all the key words and phrases on a separate sheet of paper and generated 'rules for inclusion' (Maykut & Morehouse, 1994, p. 138) for additional data cards. This was an overarching statement or proposition that summarised the meaning of the data cards and defined the parameters of the particular category. These rules for inclusion became the propositional statements. See Appendix 3C for units of meaning relating to categories 3.2 and 3.3.

9. **Positive and negative instances**. I did not revise the propositional statements on finding an occasional, isolated negative instance, only if there were several.

10. Each data card was collected into similarly coded plastic wallets and each main heading card numbered for reference. I wrote a numerical list of all the headings. This would be used later for further sorting of the data. At this stage, there were twenty-six individual categories.

11. **Exploration of relationships and patterns across categories.** I studied the many, disparate categories and searched for relationships or patterns that might link some of them together. This process gave shape and meaning to the whole. This synthesis of individual categories into a coherent whole resulted initially in five main categories or themes, called outcome propositions, which I later reduced to four. During this process, the number of individual sub-categories was reduced to twenty-two. Each of the outcome propositions carried an overarching statement (see Appendix 3D for the complete list of individual categories, rules for inclusion and outcome propositions).

12. The above process did not happen in a straightforward manner. I moved categories about over time as I continued to immerse myself in the process. Even as I continued to write up the outcomes, this process of immersion continued and further changes were made.

APPENDIX 3B

TRANSCRIPT 5

JOURNAL OF THOUGHTS AND IDEAS

This is a record of my evolving thoughts and ideas as they emerged from reading transcript 5.

- Ability to extend – common to all the counsellors. This feels important. It gives a degree of flexibility.

- Issues of trust.
- Relationship.
- Being heard.
- Being valued.

- Lack of resources. Nowhere else to refer clients to → tension for the counsellor. 'If I don't take them, who will?'

- Most counsellors usually accept the referral unless:
  →exclusion criteria
  - ❖ Psychotic
  - ❖ Eating disorders
  - ❖ Sexual abuse.

- Counsellors experience is useful → awareness that certain presenting issues may be longer term, e.g. entrenched eating disorder.

- Hates word assessment. Exploration is a better word. 'Can we work together?'

- Tension because of organisational demands especially when the counsellor has the experience to work with the client.

- Word assessment has connotations of sitting in power, judging/authority and someone else as expert. Ticking boxes, asking questions → anathema to person-centred counsellors.

It is interesting that most of the counsellors did not think that brief therapy per se, was an issue. It merely meant there was less time to work with a client. In all cases, they were able to manage the system by extending or by the clients being re-referred later. All felt they could work with whoever came through the door unless there was a strong reason why not, e.g. psychotic symptoms or other good reason. However, all felt open to work with whoever presented.

- Counsellor can never tell if it is going to be longer than 10 sessions, especially at the first session.
- Trust the client
- 'in there'
- Risk assessment. Asking questions about risk. Counsellors dislike this. Counsellor accepts there is a downside to working in the NHS.
- Tussled with whether to work with a client - working within the constraints of the service but remaining person-centred.

- Core conditions.
- Realistic outcome for end of the first session.
- Psychological contact.
- Engaging.
- Can be person-centred in brief therapy → positive view. But can't please yourself – boundaries.

The decision whether or not to offer brief therapy is based on the exclusion criteria. Mainly eating disorders. With experience, the counsellor develops a feel for which presenting issues are likely to be longer term.

Brief therapy is still better than nothing.

APPENDIX 3C

Units of meaning relating to sub categories 3.2 and 3.3

THEME 3.0

How person-centred counsellors conceptualise the process of assessment

Person-centred counsellors conceptualise the first session as an opportunity to understand the client's problems, complete any organisational administrative requirements e.g. forms etc. and to engage with and begin to form a relationship with the client. Counsellors cannot know or predict how long therapy will take and assessment is viewed as an emergent process, with counsellors using their experience and knowledge of working with clients to gauge whether counselling will be a helpful intervention and respecting the client as the expert on what is best for them.

Sub-Category name and code (category 3.2)

Process of assessment. (AP)

Rule for inclusion:

In the initial session, the counsellor tries to understand and learn about the client and begin to form a relationship of trust. It is the beginning of an exploration of whether counsellor and client can work together and whether counselling would be appropriate and helpful for the client.

R: *So if you are calling it an assessment session, what does that mean?*

P: *For the client it's assessing as far as they are concerned, it's assessing their suitability for counselling. I suppose for me all it is if I felt I couldn't work with that client, or the issues were beyond my competence.* *P1:T11*

R: *And you are assessing.....?*

P: *Well just assessing where the client is at. If work is being done. Just assessing where er I mean I'm using the term very loosely really. It's just more seeing what's going on seeing where we are this week and is counselling beneficial. You know, 'what are you taking away from it? What's come up as a result of it?' That kind of thing. So assessing, I suppose how a client has benefited, it r alt all and doing that on a sessional basis.* *P1:T12*

P: *We agreed together this wasn't rally what she wanted. She wanted something like she'd had before.* *P2:T7*

P: *So I thought, I don't think this is quite right really. So I just went back the screener and I said well I'd given it a go and I think he has found it helpful but it's really, really* *P2:T8*

hard for him and also I'm not sure that he doesn't need something else.

R: *How are you making that decision? What is the process of making that decision for you?*

P: *Well, firstly asking the client and he made it clear that it was very, very difficult. It was very hard and he was not a all happy coming to where I was working.* P2:T8

P: *It's more just is counselling going to be helpful, you know at whatever level really.* P2:T8

P: *We don't sort of say this is wrong with this client and this is wrong with this client, it's more this is what this person's problems are and this is how he's feeling and this what they want and this is what would be helpful for them.* P2:T15

P: *I see assessment in terms of what will help this client. Not so much what's wrong with them but why they are like they are and what would help them to get better.* P2:T15

R: *Assessment. That doesn't have any place in your work at all?*

P: *Well no because I work in the same way. I wouldn't sort of...I mean I could image an eclectic or an integrative counsellor sort of assessing what approach to use with a particular client but I don't need to that because they're only going to get person-centred or my brand of person-centred. So it doesn't mean an awful lot really.* P2:T16

P: *My aim and my goal is to enable a client to engage with their experiencing. So that's what I try to do. I'm trying to help them to experience themselves at a very deep level.* P2:T20

P: *I don't assess whether someone is suitable for short term work. When I meet with someone it is with a mixture of excitement at the prospect of a new relationship and a sense of challenge. How can I help this person to engage with the process with a degree of urgency so that they can get the maximum benefit from out time together? I want them to feel safe as rapidly as possible and to trust me enough to talk about what hurts straight away. And I want to give them a sense of hope that if they can do that it will* P2:T22

be helpful within the time available.

P: *So I tend to be very laid back in the early stages. But I like to let the client get to know me and I always give them a very brief description of what counselling is about. What it can do, what it can't do. Very, very simply what my approach is likely to be and if that has any problems for them. When we've got a little bit past that stage it starts to firm up a little bit because the client by that stage has got used to my voice, got used to my presence, is beginning to feel that they can start talking about more serious things and as that trust increases so they get deeper, deeper into their particular problems and the things that are causing them distress and trouble.* P3:T2

P: *I would say in the first session particularly it's a gradual process for me. All the time I'm watching and listening and trying to read into what the client is saying to me so that I have the best understanding that I can of where their difficulties lie.* P3:T2

P: *What we call assessment is much more general. We are really trying to understand what the client's problems are and whether there's a whole bunch of problems or whether there's just one of two which are really very serious and once those have been dealt with however far we can help them and then that may be as far as we can go with that client.* P3:T6

P: *What I am trying to do in the first session is to understand as much as I possibly can about the client's condition and what's unbearable. If the client happens to be one who wants to burst out and say everything before we launch into the first session then Ii am content to listen because I am still learning and trying to understand.* P3:T12

P: *I think I really regard the first session in simple language 'getting to know you.' I'm getting to know you trying to understand what you're saying, trying to understand what the problems have been, trying to empathise to the extent that I can with what you are telling me so that I can have a better understanding of what you've been through, what you've suffered.* P3:T18

P: *I think my biggest question that I try to bear in mind probably throughout my work, but certainly in that first session really, does feel really important is: am I understanding this person's world from their point of view, am I kind of getting into their frame of reference? And am* P2:T8

I feeding that back to them so they can see that I am getting into their frame of reference or at least trying to. And that being very accurate.

P: *My key aim if you like of that first session is for them to feel that they are in the right place, that they can trust me, they are in the right place to do what they need to do.* P4:T6

R *So it's 'can I be empathic, am I being empathic?*

P: *Yes, am I being empathic enough to enable this client to start trusting me? And I suppose accepting and real. They are all so tied in together, the core conditions. Almost too difficult to separate in a way.* P4:T8

P: *Have we established enough trust to work together for another 6 or 7 sessions?* P4:T6

P: *I suppose you could argue that with him we didn't have one of the six core conditions. That we weren't in psychological contact. He was unable to be in psychological contact with me. Through no fault of his own. And I was unable to be in psychological contact with him.* P4:T9

R: *So it sounds like it's the core conditions s being really central and you mentioned the 6 conditions for therapy; are we in contact etc, is the client able to..*

P: *Yeah I'd be checking those out as well. Sometimes it's not very, like with him. I knew there was something that we weren't in psychological contact but I didn't know why.* P4:T10

R: *What would indicate that for you?*

P: *Again the psychological contact and or this feeling of not being able to get into their frame of reference particularly and somebody I worked with recently. I mean my case load is very, very heavy at the moment so I wondered if there was something about my lack of energy as well a lack f energy is not the right word but the fact that I know I am at my absolute limit in terms of number of cases I am working at the moment. I found at the end of it, at the end of my session with this lady that i was absolutely wiped out and quite different to how I might normally be at the end of a first session.* P4:T11

R: *If you hadn't got the forms, because you said assessment is very driven by the organisational demands they want you to do. But separate to that it sounds like you're doing you own, in inverted commas, assessment?*

P: *I suppose I am forming my own relationship with the client is what I am doing, or what I am trying to do.* P4:T5

P: *You know at the end of that, I suppose my evaluation will be depending on what the person themselves says.* P4:T14

P: *I see if more as an exploration to see if you want to work with me, to see if I want to work with you, see if we can get on together.* P5:T2

R: *What word would you rather use?*
P: *Well what I say to the client is er I really don't like the word assessment. I see it as an exploration. To see if you want to work with me, to see if I am happy to work with you. See if we can work together.* P5:T6

P: *Um if the person is, I won't say fully functioning 'cos that means something else. If the person is functioning, is holding down a job or looking after a family and is coping with their life then I will usually take them but knowing that I am not supposed to really and just (...) it.* P5:T6

R: *You use this word 'engage' as the client engaging?*
P: *Mmnn.*
R: *How are you er...assessing (R and P laugh). You see I was hesitating using that word. How are you knowing that or assessing that?*
P: *Well I guess if I'm feeling that I'm in psychological contact in Rogers terms. Mmnn I think he says that in psychological contact, the presence of one person makes a difference to the other. The person is aware of the other person's presence, something like that.* P5:T12

P: *So er if I feel that this person is hearing what I am saying to any extent. I mean sometimes they might not be listening a lot. But if I can get some kind of response from them. Maybe some kind of acknowledgement that ..., some kind of sign that they are willing to look at themselves in any way then I will and if they can relate to me, then I will assess that as being worthwhile, I guess.* P5:T12

Sub-Category name and code: (category 3.3)

Counsellors intra-personal experience (CIE)

Rule for inclusion:

The process of assessing whether counselling would be a helpful intervention is hard to define. It starts at a feeling level and by being reflexive, the counsellor may be able to articulate this at a cognitive level.

P:	*You can never know really. I suppose it's a gut feeling, it depends on what comes out and how the client is I suppose, um yeah it's just something you gain with experience. It's hard to just define it I suppose. Um (long pause), yeah, just how the client is. You can tell very quickly in the session, I suppose without being judgmental of course.*	*P1:T3*
P:	*I suppose it's never concrete. It's I feel this person may need more than 6 sessions. And very often what I will do.*	*P1:T6*
R:	*I'm wondering about those clients for whom you feel "I could work with this client, but it's going to be long term." How do you know that? Do you ever get the sense this is going to be longer than 6 session? I am just wondering about the process of knowing that?*	
P:	*I keep avoiding it don't I because I'm not sure what that process is. It's just a knowing.*	*P1:T8*
R:	*So it's a sort of knowing, and you said gut feeling before?*	
P:	*It's a sensing. We do have a lot of knowledge of human systems. I think I'm probably reluctant to say this because it goes against my belief in person-centredness really. Each individual existing in their world and being able to hear that person, and without making any judgments, without any preconceived ideas. Instinctively you know when somebody starts to talk about something and you hear their life history, there is some kind of pattern that does go on. And I hate to say that because I'd like to believe there isn't. But actually there is.*	*P1:T8*
R:	*Similar threads that you may pick up? That although every person may be unique there are some similarities, some commonalities?*	*P1:T9*
P:	*So it's about a gut feeling, it's a knowing-ness (pause).*	
P:	*But again it's gut feeling. Sometimes I use that as an assessment session. I call it an assessment session and sometimes I don't. I can't tell you why I do that but it's just again, gut feeling. I don't know.*	*P1:T10*

P: *Yes I just thought, this is not right.* P2:T9

P: *So I suppose first of all it's at a feeling level. I get the feeling this is not comfortable for this person. But then I can justify it cognitively. I can come up with reasons as to why in order to explain why I'm either discharging them or referring them on.* P2:T9

P: *Well yes because I think my feelings and senses are based on signals that I'm getting from the client although I'm not necessarily processing those in a reasoning way. That's obviously what I'm basing this feeling on so I just need to have a think about it really and work out why it is that this person is not suitable for counselling.* P2:T9

P: *Sometimes I get the feeling that that isn't going to be quite sufficient for this particular client.* P3:T1

P: *An example might be, I worked with somebody a couple of years ago and his presenting sort of when I first me him on our first session, I just felt like there was no connection in terms of, he wasn't looking at me, he found it very difficult to say anything.* P4:T2

P: *But to be honest, it's so vague that I kind of just think well I'll just go with my own organismic self I suppose, my own gut feeling with the client.* P4:T5

R: *So if that feels difficult, if you are feeling that you are not, what's happening there?*

P: *I would be trying to check with myself what's blocking me. I don't know. I'd be trying to work out if I am getting that sense of that I am not getting into this person's frame of reference or I am not understanding their world from their point of view. Then I would first of all do my own self checks. This is all kind of in the here and now. Is it, you know, am I blocking this person because it is something about them that reminds me of somebody or is there something about what they are saying to me.* P4:T8

P: *So I do check things. Is she touching on my stuff and if so, or is he touching on my stuff and if so what can I do about that. And sometimes just recognising that enable it so shift so I can get back in touch with what they are saying. Or I am thinking put like a sticky on the wall if you like, in my mind reminders this is someone to take to supervision or I may be confused as to why I am not connecting with them or not being empathic enough with them. So I try to work* P4:T9

out if it's me and sometimes, like with the guy who turned out to be autistic, it might be actually that there's something coming from them.

APPENDIX 3D

OUTCOME PROPOSITIONS AND STATEMENTS

OUTCOME PROPOSITION 1
(THEME/CATEGORY 1)
Counsellors' phenomenology of working within a brief therapy model
Person centred counsellors have found they are able to work in a brief therapy setting although certain tensions may arise as a result of organisational protocols and procedures; form filling, such as risk assessment documents may need to be completed in the first session which may compromise the person-centred counsellors way of being. Sometimes brief therapy is viewed as part of a longer process but it is also recognised that a great deal can be achieved within a few sessions. It is perceived that clients respond to the limited time by getting on with the work of counselling. A client's readiness for counselling is considered important.

Sub-category name and code:
Counsellors positive attitude towards brief therapy (CPA)

Rule for inclusion:
Person-centred counsellors have a positive attitude towards brief therapy as being an effective intervention for clients.

Sub-category name and code:
The influence of the brief therapy model on the client's process (EBC).

Rule for inclusion:
Knowing there is limited time, the client is motivated to get on with the work.

Sub-category name and code:
The influence of the brief therapy model on the counsellor's process (IBC).

Rule for inclusion:
Counsellors are always mindful of the time boundary and clients and counsellor have to work hard from the beginning.

Sub-category name and code:
Clients readiness for counselling (RC).

Rule for inclusion:
It is felt important for clients to be ready to address their issues and begin the work of counselling.

Sub-category name and code:
Tensions arising from organisational requirements in the first (assessment) session (TE).

Rule for inclusion:
Organisational requirements to complete assessment forms in the first session may compromise the person-centred counsellor's way of being. Additionally,

the constraints of working to a brief therapy model mean that sometimes counsellors find it difficult to refuse a client for therapy when they know that if those constraints were not there they would have accepted the client for counselling.

OUTCOME PROPOSITION 2
(THEME/CATEGORY 2)
The person-centred relationship in brief therapy.
Counsellors offer the core conditions of empathy, positive regard and genuineness to create a trusting therapeutic relationship. This is seen as essential for the client to move along with the work of counselling and no different from working with clients in the longer term. Occasionally, CBT techniques were used if this felt appropriate for the client.

Sub-category name and code:
Being person-centred (BPC).

Rule for inclusion:
The counsellor's way of being is not generally compromised by working in a brief therapy setting except in the first session when there may be an organisational requirement to complete assessment forms. This can affect the process of beginning therapy and feel like adopting a position of power.

Sub-Category name and code:
Process of building a relationship (R).

Rule for inclusion:
The counsellor offers the core conditions as intensely as possible to build up a relationship with the client as quickly as possible.

Sub-Category name and code:
Trust (T).

Rule for inclusion:
Counsellors value trust as a key element of the relationship for the work to begin.

Category name and code
The influence of the CBT model (CBT).

Rule for inclusion:
Some counsellors acknowledge that their practice may sometimes be influenced by the CBT skills model.

OUTCOME PROPOSITION 3
(THEME/CATEGORY 3)
How person-centred counsellors conceptualise the process of assessment
Person-centred counsellors conceptualise the first session as an opportunity to understand the client's problems, complete any organisational administrative requirements e.g. forms etc. and to engage with and begin to form a relationship with

the client. Counsellors cannot know or predict how long therapy will take and assessment is viewed as an emergent process, with counsellors using their experience and knowledge of working with clients to gauge whether counselling will be a helpful intervention and respecting the client as the expert on what is best for them.

Sub-Category name and code:

Meaning of the word assessment for the counsellor (MWA)

Rule for inclusion:

The word assessment can sometimes imply power or passing judgment on the client, or categorising the client according to pre-determined definitions of the client's presenting issue. This concept is anathema to the person-centred counsellor.

Sub-Category name and code:

Process of assessment (AP).

Rule for inclusion:

In the initial session, the counsellor tries to understand and learn about the client and begin to form a relationship of trust. It is the beginning of an exploration of whether counsellor and client can work together and whether counselling would be appropriate and helpful for the client. The counsellor tries to engage with the client's process and help the client to engage with the process.

Sub-Category name and code:

Counsellors intra-personal experience (CIE)

Rule for inclusion:

The process of assessing whether counselling would be a helpful intervention is hard to define. It starts at a feeling level and by being reflexive the counsellor may be able to articulate this at a cognitive level.

Sub-Category name and code:

Counsellors experience (CE).

Rule for inclusion:

Counsellors' training and experience of working with clients helps them to recognise patterns or similarities which help them gauge where the client is in their process and whether counselling may be helpful or appropriate.

Sub-Category name and code:

Client autonomy (CAE).

Rule for inclusion:

The counsellor respects the autonomy of the client to know whether brief therapy will be a helpful intervention.

Sub-Category name and code:

Emergent process of assessment (K/NK).

Rule for inclusion:

Counsellors cannot predict or know when they first meet a client whether the work will be long or short term and view assessment to be an emergent, ongoing process and not something that can be completed in the first session.

Sub-Category name and code:

Contracting (CFS).

Rule for inclusion:

Counsellors spend some time in the first session going through the business of formal contracting giving information on the boundaries, the process and administering any assessment tools that are required by their employing organisation.

OUTCOME PROPOSITION 4
(THEME/CATEGORY 4)
Managing brief therapy

Counsellors use the option of extending the number of sessions to manage the brief therapy process. Decisions about whether the client would be appropriate for brief therapy did not have to be made in the initial session and brief therapy was viewed as part of a longer process. Counsellors trusted the client as expert and accepted all who wanted brief therapy. Counsellors may also use supervision for further advice/support.

Sub-Category name and code:

How clients are referred to the counsellor (HR).

Rule for inclusion:

Referrals may come from other health professionals who refer according to organisational protocols, or they may self-refer. Self-referrals receive an initial screening interview. Furthermore, when clients present with certain severe or complex presenting issues the counsellor may decide that a referral to secondary mental health services or to an external, non-statutory agency would be more appropriate.

Sub-Category name and code:

Referral pathways for the counsellor (RP).

Rule for inclusion:

Counsellors, particularly in healthcare settings, are able to liaise with and refer clients to other health professionals if further input is needed. However, there are limited opportunities for signposting clients to other, non statutory, counselling agencies.

Sub-Category name and code:

Accepting all clients for counselling initially (AAC).

Rule for inclusion:

Counsellors accept clients on the basis that if they are willing to come for counselling they will offer them brief therapy even if initially the problems may seem complex because it is felt that much can still be achieved.

Sub-Category name and code:

Options to extend therapy (MBT).

Rule for inclusion:

Brief therapy is sometimes seen as the first stage of a longer process and counsellors use the option to extend as a way of providing further sessions for those clients for whom it would be inappropriate to end, on the basis of risk or severity of presenting issues.

Sub-Category name and code:

Importance of the first session (as the beginning of the therapeutic relationship) (IFS).

Rule for inclusion:

The initial (assessment) session with the client is not always considered to be a stand alone session but the beginning of the therapeutic relationship and it is often found that a great deal can be achieved in this first session.

Sub-Category name and code:

Counsellors use of supervision (US).

Rule for inclusion:

Counsellors may use supervision to explore whether it would be appropriate to offer brief therapy to a client.